

# Melody in Music Therapy

A Therapeutic Narrative Analysis

Gudrun Aldridge and David Aldridge





## Melody in Music Therapy

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## A Therapeutic Narrative Analysis

*Gudrun Aldridge and David Aldridge*



Jessica Kingsley Publishers  
London and Philadelphia

First published in 2008  
by Jessica Kingsley Publishers  
116 Pentonville Road  
London N1 9JB, UK  
and  
400 Market Street, Suite 400  
Philadelphia, PA 19106, USA

[www.jkp.com](http://www.jkp.com)

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#### **Library of Congress Cataloging in Publication Data**

Aldridge, Gudrun, 1947-

Melody in music therapy : a therapeutic narrative analysis / Gudrun Aldridge and David Aldridge.  
p. cm.

Includes bibliographical references and index.

ISBN 978-1-85302-755-0 (alk. paper)

1. Melody--Psychological aspects. 2. Melodic analysis--Psychological aspects. 3. Music therapy. I. Aldridge, David, 1947- II. Title.

ML3834.A43 2008

615.8'5154--dc22

2007026945

#### **British Library Cataloguing in Publication Data**

A CIP catalogue record for this book is available from the British Library

ISBN 978 1 85302 755 0

ISBN pdf eBook 978 1 84642 762 6

Printed and bound in Great Britain by  
Athenaeum Press, Gateshead, Tyne and Wear

*This book is dedicated to Gisela Behrens.*

## Acknowledgements

We would like to thank our colleagues at Aalborg University on the PhD course for their commentaries on this study, in particular Lars Ole Bonde and Tony Wigram. In any research project, it is necessary to have lively and knowledgeable discussion in a supportive setting, and the PhD course in Aalborg provided such a forum.

Simon Gilbertson and Wolfgang Schmid, in their doctoral dissertations at the Chair of Qualitative Research In Medicine, University of Witten Herdecke, have successfully applied the therapeutic narrative analysis approach in extended settings – see Aldridge, D. (2005) *Music Therapy and Neurological Rehabilitation: Performing Health*, London: Jessica Kingsley Publishers.



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## Melody in the Context of Music Understanding

To begin we have to take a journey back in time. It is 1961, the school bell rings for the dinner break, and one of the authors rushes off to make sure his blow-wave has not wilted. With sixpence in his hand, he and best pal, Johnny Henshaw, sneak out of the school grounds to the local version of paradise on earth, a café with a jukebox. With that sixpenny piece, it is possible to hear Roy Orbison singing last year's 'Only the Lonely' and the current, monumental 'Running Scared' flipsided by 'Love Hurts'. And the memory still remains of those opening bars, 'Dum dum de dummy doo aah, wo yeah yeah yeah yeah, oh wo wo wo-aarrh, only the lonely'. But you have to locate this alongside the fact that we were smoking the first not-behind-the-bike-sheds cigarette of the day (these were the days before the home health security agencies were having their crackdown). Illicit enjoyment was the binding force accompanied by the pertinence of the lyric. What do you do when you've lost your girlfriend when you are fourteen? OK. I hadn't had one to lose, but still the great Roy O's song made sense, if I had had one. And I really did want one, so here was that sweetness of adolescent longing along with that wonderful Wurlitzer jukebox sound. Reminiscence is one of the contexts of music understanding; music exists in times and spaces, and these are personal as well as historic.

Jump ten years, and the same person, with a different hairdo, is sidling into a downtown bar in Nuneaton (somebody has to come from there). The price of the jukebox has changed but not the thrill. This time, he chooses The Byrds' 'Mr Tambourine Man' and waits for those memorable shimmering opening bars of Jim McGuinn's 'Rickenbacker', where the very sound itself evokes shadows of The Everly Brothers and The Searchers. If he times it right, the beer will be poured just as the song is starting. So much simple anticipation. A degenerate career is under way

and music is his travelling companion. And linking these events is the chain of melody, its painful pleasures and evocative memories of a life between and through bars.

Some years earlier, the other author has picked up her accordion to play 'Ich weiss nicht was soll es bedeuten, dass ich so traurig bin?' For her the holidays have ended and the summer too is coming to a close. School beckons. Her mother, Gottingen's answer to Rainer Fassbinder, asks her to play the musical accompaniment to a home movie, 'Hurrah for the Holidays'. So she chooses this song with its yearning evocative lyric. This is the memory that she first recalls when asked what is the first instance of melody that comes to mind.

Melody is an important element of music and has significance for many people. It involves internal experience and memory and serves as an intimate accompaniment to many stages and situations in life. We have sense of place, reminiscence, pleasure, culture and sound. We identify with melodies. We may also assume that melody – in whatever manifestation – has always been and still is the most common and best-known aspect of music at all times and in all civilizations. It is an integrative, and important, means of expression in many different societies. We all know what melody is – or do we?

Melody is one of those aspects related to the nature of music and its meaning in general. It is difficult to decide exactly why one melody is more appealing to us than another, why it lives on in us, moves us and may even be so insinuating that it is hard to shake off.

Some composers point out that melody is the essential core of music, and music without melody is unimaginable. Eimert calls melody within atonal music 'the highest expression of the atonal idea', and even Alban Berg advocates a 'singable melody' (Blume 1989a, p.23). In the historical development of melody, we see the paradoxical nature of the concept 'as the only unchangeable element in its thousands of years seems to be the lament that it is – or still is – nonexistent' (Abraham and Dahlhaus 1982, p.10).

Johann Mattheson (1739, p.133) describes this paradox with the following remarks:

This art to make a good melody grasps what is essential in music. It is therefore very astonishing that almost every teacher has so far neglected an aspect of such importance. It has been overlooked to such a degree that even the most prominent masters – and among them those with the widest and latest experience – have to admit that it is almost impossible to name any rules, giving as an excuse that most of it depended on good taste; but good taste in itself can and must be governed by the most thorough rules.

## Etymology

The word ‘melody’ is derived from the Greek *melodia* and consists of the two Greek words for tune and singing or song. The literal translation is something like ‘singing tune’ (Blume 1989a). The main component *melos* is important for the meaning of the word melody (melodia).

Originally, *melos* is not used as a musical term, but as a *pars pro toto* term for the entire body of humans or animals, to be understood as a structured organic entity (Blume 1989a, 595). If we consider that instead of the biblical injunction that ‘In the beginning was the word’, and substitute, ‘In the beginning was logos, as music’ (Aldridge 1996b); then we can see that the material explication of this logos is *melos*, the living body of organic unity as form explicated. Although we are many, we are one melody.

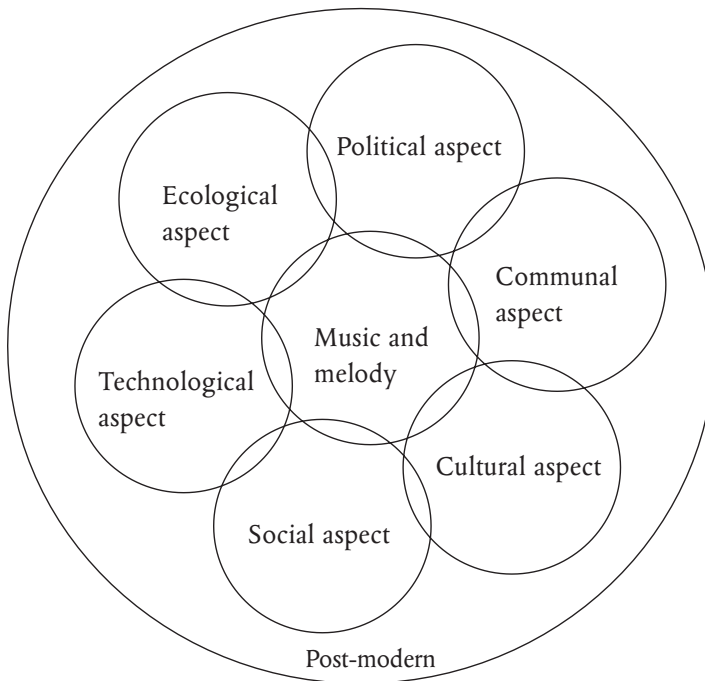
As a musical term, the word *melos* appears first in Homer’s and Hesiod’s mythological and epic poetry. From that time onwards it has denoted a sequence or series of notes constituting a structured organic entity, in accordance with its original use but no longer on a grand scale.

Dahlhaus (Abraham and Dahlhaus 1982, p.72) addresses the question of the role of etymology and historical meaning of the term melody when he asks in general:

Do we have to deplore the narrowing of a term as a loss of meaning, or do we welcome it as an improvement in exactness? Is the rehabilitation of the original (broad) meaning of a term and its expansion in favour of current (or future) difficulties of terminology mutually exclusive?

We need both narrow and broad concepts of the term to explain its meaning. Exact, precise definitions facilitate analysis. However, they may prove too narrow where a context of meanings has to be explored and act as an obstacle for access to a term. On the other hand, an understanding that is too broad runs the risk of losing focus.

In the context of this study, where interaction between patient and therapist and the patient’s expressive statements in the musical–melodic improvisation are in the forefront, the original etymology will help us to develop new perspectives and to integrate aspects that have been lost in the current musicological approach with its concentration on technical elements only. In our understanding melody has to be located in a cultural context that incorporates a variety of differing aspects (see Figure 1.1) The focus is on the melody improvised with the patient. The question therefore is how the patient develops his melody and thus finds his own voice. How can a patient determine his or her own position within a structured organic wider context? How do therapist and patient relate to each other?



*Figure 1.1 Music and melody and varying aspects of the post-modern context*

## Historical roots

Historically, and in contrast to an almost uninterrupted tradition of a theory of counterpoint and harmony, there is no continuous theory of melody (Abraham and Dahlhaus 1982; Blume 1989d; Edwards 1956). The need for such a theory is newly discovered and proclaimed in almost every century. Abraham and Dahlhaus suspect that one of the reasons to prevent a sustained theory of melody must be seen in the insecure position and function of melody within the system of music theory. This insecurity is revealed in the doubt whether melody has an elementary, a fundamental or, on the contrary, a summarizing significance that includes a theory of rhythm and of harmony. And that is what you get from trying to split things up, you lose the bigger picture.

Attempts to establish melody theories were made in almost every century. The only law of melody to be passed on from epoch to epoch states that a leap should be compensated through tonal steps in the opposite direction (Blessinger 1930; Blume 1989a).

Another reason for the lack of a traditional theory of melody lies in the development of thinking in music theory. In the middle ages, the focus of this thinking was directed exclusively to the theory of monophony. The entire medieval music theory

therefore is basically that of melody. This musical thinking, following melodic linearity, continues to prevail also during the subsequent period of polyphony, which was first understood as a simultaneous ringing out of several melodies. It concentrates on the horizontal formation of vocal lines, and becomes apparent in their linear autonomy. As an awareness of harmony emerges, the understanding of melody in the sense of linear vocal guidance is reduced and becomes absorbed (Abraham and Dahlhaus 1982).

A crucial turning-point is the far-reaching change in composition techniques around 1730, when linear principles are supplanted by the periodic principle. This change becomes most apparent in the homophonic movement with the dominant melody in the upper voice and its period formation derived from dance. In songs and dances, the period formation has always shown a tendency – in the structure of verses and sequence of steps – towards symmetry and dual forms; i.e. to correspondence and analogies. Melodies of the classical epoch often have a schematic harmony that serves not as the substance of melody but as its supporting background against which the diastematic–rhythmic events and nuances stand out in relief.

The dominance of an emerging theory of harmony, which completely absorbs the theory of melody, is in part due to the traditional heritage of the nineteenth century as a ‘harmonic’ chapter of style in music history. In the foreground are modal fifth-octave structures or tonal models of chromatic chords on a mediant, but not the melody itself with its specific individual tonal relationships. Harmony is structured systematically, but not melody.

Composers and theorists of that time already point out the various musical moments that may be relevant within a melody. Wagner advocates the ‘never-ending melody’ that ‘flows like an uninterrupted stream through the entire work’ (R. Wagner in Meierott and Schmitz 1980, p.156). The inner cohesion of his musical dramas is achieved by ‘a tissue of basic themes’ that ‘are to appear as a complementation or demonstration of persons’. Sung prose melody reflects the person’s individual character, while the orchestra becomes an instrument to interpret the melody. With the support of numerous harmonic–motivic and melodic references, the leit-motif underlines the emotional relations between persons and events that are not expressed verbally in the text.

Consequently, melody is seen today as an historical issue that is not only influenced by the development stages in music but incorporates them as a substantial part. These historical facts also imply definite concepts and expectations as to what music should comprise. They emerge as musical–aesthetic ideas and paradigms that derive from musical experience and are also closely connected with changing historical conditions.

## Aesthetic background

...das freie Tönen der Seele im Felde der Musik ist erst die Melodie

...the free tones of the soul in the field of music is first the melody

(Hegel in Nowak 1971, p.134)

The term 'aesthetica' was coined by the philosopher Alexander Baumgarten as late as 1750 and from then on has been established as an independent philosophical discipline.

Dahlhaus considers the many attempts to define aesthetics – be it as a theory of perception, a philosophy of art or science of fine arts – as too narrow, dogmatic and one-sided in view of the ambiguity of the phenomenon (Dahlhaus 1967). For him, a more precise and pertinent definition of this term must involve the fundamental acknowledgement that this is not so much a clearly defined discipline but a rather vague and comprehensive term. It presents itself as the quintessence of problems and numerous different perspectives that have grown together under one name.

### *Aisthesis*

Baumgarten's 'aesthetics' developed into an independent philosophical discipline in Germany in the eighteenth and nineteenth centuries. From the Greek root, 'aisthesis', as perception and sensuous cognition, the term first described a theory of perception that what is beautiful is sensuously perfect (Dahlhaus 1967; Welsch 1994).

'Aesthesis' describes perception on the one hand, and sensation on the other. While the sensuous component is directed at genuine sensuous qualities, like colours, sounds, tastes and smells, perception serves to grasp these on the level of cognition. The sensuous component of 'aisthesis' is emotional and assesses the sensuous within the horizon of desire and aversion. There are gradual differences between both approaches. While desire is a primary sensual pleasure that is determined by vital interests, perception must keep a distance for the sake of cognition. The distance is necessary in order to be able to determine the sensuous attributes as objectively as possible. The emotional side also changes – because of the need for pure perception – and reaches a higher level, the enjoyment of a reflexive pleasure or displeasure. This perspective assesses its object not as the primary sensation of vital criteria – as inciting, savoury, or disgusting – but according to reflective criteria like beautiful, pleasant, harmonic or repulsive, ugly and disturbed. Kant described this difference in standards as the ground of the sensual and the basis of reflective taste (Welsch 1994). Both levels reveal the origin of the specific aesthetic sense which is



that of taste. Nevertheless, the immediate is separated from the reflected; the vulgar from the refined, Orbison from Orff and Offenbach.

Bourdieu, however, offers another take on this perspective that rescues all of our compatriots who celebrate vulgarity and bad taste, placing the understanding of the aesthetic in a cultural frame:

A pure aesthetic expresses, in rationalized form, the ethos of a cultured elite or, in other words, of the dominated fraction of the dominant class. As such, it is a misrecognized social relationship. 'The denial of lower, coarse, vulgar, venal, servile – in a word, natural – enjoyment, which constitute the sacred sphere of culture, implies an affirmation of the superiority of those who can be satisfied with the sublimated, refined, disinterested, gratuitous, distinguished pleasures forever closed to the profane. That is why art and cultural consumption are pre-disposed, consciously, and deliberately or not, to fulfil a social function of legitimating social differences.' (Randal Johnson quoting Bourdieu as preface to Pierre Bourdieu, 1993)

### *Aesthetic experience*

Roman Ingarden (1968, p.199) also addresses the emotional perceptive component of 'aisthesis' and describes how an aesthetic experience occurs and what it may produce. His term for the emotional component is 'original emotion', a feeling produced in the listener or observer by the object of aesthetic experience. It is that specific quality of an object that does not leave the listener/observer 'indifferent'. The specific aesthetic experience therefore presupposes a state of being moved, a subjective emotional relation between the work of art and the observer. For Ingarden, the state of being moved is the essential precondition for aesthetic experience. This state of being moved or disconcerted, the 'original emotion', may have the following effects:

- The actual reality fades into the background of interest in order to make room for the stimulated sense, e.g. the auditory or visual sense. This has a focusing or a certain narrowing effect on the field of perception to one single sense and at the same time causes a reluctance to act.
- The 'now' of the aesthetic experience is of a different nature. It differs from the 'present' moments of everyday life. At the moment when a person changes over from a practical to an aesthetic attitude, she acquires a new self that starts a new perception of time. Aesthetic life means life in the moment.

- Most important from the aesthetic perspective are qualities and relations, the question of 'how'. The aesthetic viewpoint or what is perceived aesthetically lingers with the state of being moved and does not try to penetrate the object. The actual quality of 'being' fades into the background while the fascinating quality becomes the centre of crystallization for the activity of imagination.

The 'original emotion' described by Ingarden disconcerts an observer; she feels an inner need to enjoy to the full the quality that has stimulated this disquiet and returns to it. An interplay between the observer and the object starts; her imagination demands a certain complementation for the quality that has disconcerted him. The observer reproduces the object in her imagination, she re-creates. This animated process of creation is directed at the aesthetic object, is therefore the listener's or observer's target of intent and attention. Ingarden (1962) uses intention in this context in accordance with Husserl's phenomenology. For him, 'intentionality' is the quality of any consciousness to be consciousness *of* something. Therefore, the processes of perception, imagination, questioning, wishing, being delighted or disappointed are all intentional activities because they always refer to an object or circumstance.

This creative process stimulated by the 'original emotion' causes an observer to recreate in himself the aesthetic object (landscape, picture, poem, work of music). Within the scope of the music therapy presented here, we see this as an active process realized in the performance of a musical improvisation.

This turn towards activity as process plays a role in Shustermann's pragmatic aesthetic (Shusterman 1992). Aesthetic experience is not only an object, as part of a narrow conception of high fine art; it can also be found in the body, in ritual, sport, the media of pop culture, and in various colourful scenes and moving events that enrich our ordinary lives. The aesthetic of the body is not limited to its surface form but to how the body moves and experiences itself. We refer to this as a praxis aesthetic when referring to how we talk about music therapy and relational aesthetic when we come to interpret relationships.

Dewey (Shusterman 1992) considers all art as the product of interaction between the living organism and its environment. This involves a reorganization of energies, actions and materials. Aesthetic experience emerges by doing; engaging those feelings, energies and physiological responses necessary to appreciate art. For Dewey, naturalism, in the broadest sense of nature, is necessary of all great art, for art's role is to give satisfyingly integrated expression to both, bodily and intellectual dimensions.

### *Art as given by nature*

The notion as to what melody should comprise is the result of an aesthetic concept from the eighteenth and nineteenth centuries, a period considered as an epoch of aesthetic reflection relating to prevailing concepts of art going back to Renaissance art theory, Kant's 'Critique of Judgement' and Wagner's theory of the musical drama (Dahlhaus 1967). Art should appear as 'given by nature' and not as 'produced'.

Music and other arts, in order to be considered art, had to appear as an imitation of nature. Nature was seen on the one hand as the external nature, and on the other the internal nature of human beings as feelings and states of mind. According to the concepts of this time, melody is the essence of what is 'given by nature'. The artificial character of melody is not denied, because of its form and structure; but the claim prevails that melody must appear as a piece of nature and not as an artefact. Natural melody was seen, on the one hand, as the limited and regularly structured interlude, and on the other, as a singable and expressive episode. A consequence of this rejection of the artificial was that a feeling for musical reflection and a grasp for extended melodic patterns was lost. Any awareness of how a melody is generated failed to develop.

### *Inspiration aesthetics*

Another factor to influence our current concept of melody is the inspiration aesthetics of the nineteenth century, which differentiates strictly between the melodious, naturally given idea (the inspiration) that cannot be taught, and an artistic, stylistic-formal composition. From this perspective, musical expressivity is best uttered as melody. These concepts were influenced by Hegel's aesthetics of music implying that the human being can best express her inner world by melody, and in doing so, simultaneously releases herself from the bonds of suffering or enjoyment (Abraham and Dahlhaus 1982).

For Hegel, the inner self of the human being is not only absorbed in itself, but at the same time is able to stand beside itself. By experiencing a feeling, both present and distant at the same time, we achieve release. Hegel saw this double character of feeling, emphatic and distanced at the same time, justified in the connection between melody and rhythm and the tonal harmonic of the time. In these rules and structures, he sees not so much a restraint but rather a support for melody so that it does not dissolve into shapelessness. Melodious expression strives for emotional expression and distances one's self from those emotions at the same time; an attitude that still prevails in some writings about the justification for music as therapy.

### *Resounding movement*

Several representatives of musical aesthetics in the twentieth century base their theories on the general opinion that music is resounding movement. These theorists, also called 'energeticists', explain their theories by a hypothetical energy that August Halm called 'will' and Ernst Kurth called 'power' (Dahlhaus 1967). Kurth went back among other things to Riemann's observations on the inner dynamics of melodic-rhythmic forms. His theory of 'kinergetic energy', however, reduces the inner dynamics of rhythm and harmony to the melody shape as the musically 'original'. Kurth's attempt to reify 'movement energy' as an entity met with opposition within the system of music aesthetics and theory. It is generally accepted that movement may be seen as a 'basis' of music, but it is recognizable only indirectly and not immediately in itself, in the concurrence of melodic and rhythmic elements (Blume 1989a, p.39).

The phenomenon of movement is closely connected with that of the tonal range. From the perspective of the melodic element, the difference between successive notes turns into imaginable distances in space. However, notes are not only perceived as high or low but also as light, dark, piercing, soft, warm or heavy.

### *Dynamic form*

Form, for Boris de Schloezer (Zimmermann 1978), is not a reasonable classification system, like a sonata or rondo in the study of musical form. These provide only the plan for creative activity, the frame within which organic systems are created. Melodies are organic systems. He compares them with living bodies consisting of limbs and parts that receive their aesthetic meaning only as parts of one entity, in their interdependence and in relation to each other. For Schloezer, form is not the receptacle but the content. It is dynamic and turns its elements into something organic, into limbs. What evokes the listener's aesthetic attitude, his being moved, and appeals to him is the inner form of the organic, individual and unique work of art. This fundamental aesthetic perspective proposes that the work of art carries its perfection in itself, expressing a world that the listener has to experience actively, so that it may become tangible as an organic idea. The original separation of perception and action are here united.

### *Aesthetic as performance*

In the 1960s, there was a movement to bring art from out of the galleries and onto the streets. Those of us trained as artists at this time were not only interested in bringing art to the people, even if they were a lumpen proletariat, but also concerned with art as an activity. The work and its viewer are as important as the artist. Art is the

happening and becoming of understanding, not fixed but performed. This was the destruction of objectification and the prioritization of experience. Rather than Kantian reflective speculation, we championed Nietzschean identification. Beauty was bourgeois. Aesthetics was to music as apiarian studies is to the bees. Doing art, making music, performing dance had a moral and practical value for the communities taking part with an expectation of breaking free of convention. Works, as workings, became intimate performances as relationship with the audience. Here we have the roots of the praxis aesthetic and a relational aesthetic proposed here for music therapy (Aldridge 2000). These aesthetics are based upon relationship, and intimate performance, with mutual moral responsibility for each other.

In such a relational context, therapy becomes a meaning-making activity where the truth is not determined, conventions are broken and sense is performed. Just as in a community arts sense, the public performs meaning too, in therapy there is also a mutual performance of meaning. Aesthetic is dislocated from the purely privatized to the relational and contextual. This performer stance brings another perspective to truth claims. Truths are the little truths of everyday life, which have no grand standing, but have the validity of mutual recognition. There is no radical separation between work and performers. And these truths emerge as presented in the performance; the work – in performance – has a presence of something else within itself. To discover that presence is the task of this book. The challenge for music therapy research is that if the aesthetic is relational, it is not a quantifiable thing. We must, then, adopt an hermeneutic perspective.

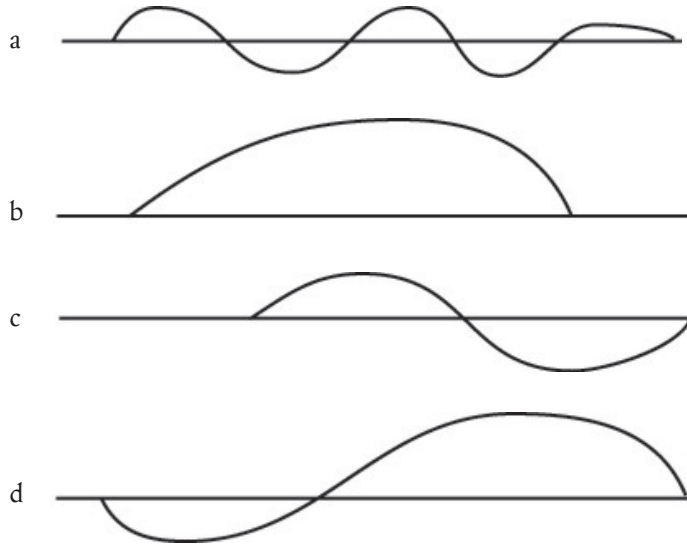
## Characteristics of the Current Concept of Melody

Our contemporary comprehension of the concept of melody is both extensive and restrictive. The extensive point of view defines melody as that which consists of the three elements:

- rhythm (temporal structure, order of movement of sounds)
- harmonia (matching sounds ringing out simultaneously)
- logos (language, text, word).

The narrow definition sees melody as a sequence of sounds that differ in height and depth, as diastematic notation – the horizontal sequences of tones (diastema is the gap between two teeth). This is how we perceive the proportions of tension in the relationship of subsequent notes and their relation to each other. Since antiquity, this quality of melos has been defined as an emergent process. According to Aristoxenos of Tarent, an understanding of music is composed of the perception of what is emerging and the memory of what has emerged. Not only the now, but what was once and what is becoming. As we will see, these are important aspects for music therapy.

Diastematic notation has highly stylized developments (see Figure 2.1). In Figure 2.1a, we see a melodic curve starting from the centre note that is often called a wave movement. Beethoven's 'Ode to Joy' from the last movement of his Ninth Symphony typifies this. Figure 2.1b illustrates the arched curve of an ascending and descending line, the simplest and most natural-appearing line within our concept of melody. Rise and fall in the sense of tension and relaxation are present in melodies



*Figure 2.1 Stylized melodic development: (a) melodic curve, (b) arched curve ascending and descending line, (c) unfolding version of an arched curve, (d) mirror image of an arched curve*

that aim at comprehensibility and clarity. This type corresponds to the Moldau theme in Smetana's cycle 'My Fatherland'.

Figure 2.1c may be seen as an unfolding version of an arched curve, with an expanded and rounded-off curve, while Figure 2.1d is its mirror image. The latter melody line is rather rare, because its downward direction appears less natural. The final theme of Brahms' First Symphony is an example of this latter typical line, d.

Tonal tensions resulting from the melody line are mainly dependent on the tuning system being used (natural or tempered tuning), the compositional style, the historically or individually developed perception and the timbre. Subjective factors are highly significant in this context. This interplay of tensions in the diastematic line might be the reason for one of the few valid rules that demands that a leap must be followed by a step in contrary motion.

Melos is not limited to mere differences in pitch, and incorporates several factors:

- First, melos has a direction and moves within the tonal space.
- Second, the impression of distances may either be seen as an analogy in space, or mean that more or less nuances are assumed to exist between two notes, comparable to the distances between red and blue or red and violet.

- Third, a leap between notes presumes intermediate steps. The third in the pentatonic system is not considered as a leap. The impression of a 'step' or 'leap' is also determined by tonal relationship. The term 'distance melodics', sometimes used in the sense of tempered scales, contains the psychological implication that equal proportions of oscillations are recognized as equal distances in tonal perceptions.
- Fourth, the starting and final notes as well as the highest and lowest notes constitute the *points d'attraction* that articulate a melos without having to be reduced to tonal relationships and movements.

Husserl (cited in Blume, 1989d) refers to the partial qualities of a melody when he describes listening to melody as a synthesis of explication, since this always implies a summary of various moments, like diastemy, rhythm and dynamics. He points out that despite a concentration on individual elements, it is an interest in the entirety of the melody that remains the focus of observation. Consequently, melody has to be considered a comprehensive musical phenomenon. It is composed of many individual characteristic elements, which in their unity determine the overall melodic appearance and expression.

The Riemann dictionary defines the content of the contemporary melody concept as follows (Dahlhaus and Eggebrecht 1979, p.110):

Melody is an independent tone-movement that unfolds itself in the matrix of time and is distinguished from other less independent sequences of tones (minor part, counter part, second/third part, accompany part, filling parts) by its inner logical consistency, or vocalizability, or easy comprehensibility, or by firmness and unity of its gestalt, and includes the element of rhythm in its concrete expression.

This quotation stresses the aspect of formation and gestalt and may be completed by attributes of self-sufficiency, self-containment, structure, organization, singability, monodism and catchiness. Such adjectival expressions are found in common language as melodic, tuneful, melodious and unmelodious. Musicians and amateurs often use these attributes. Schoenberg (1967, p.48) comments on characteristics of the 'unmelodious'. For him, this involves imbalance, lack of cohesion, insufficient integration with harmony or accompaniment, and lack of concord between phrasing and rhythm. In his own compositions, Schoenberg always maintains the general reference to a continuous beat, despite individualized rhythmic elements. From his perspective as a composer and music theorist, he speaks of the melodic sense as part of the creative talent that enables those who possess it to do the right



thing by instinct. Since these are creative skills, however, there can be no rules for imagination.

Melody is the prototype of gestalt. The modern theory of gestalt demonstrates that what we immediately perceive is not amorphous or ill-organized, but structured. In psychology, the morphology designed by Wilhelm Salber proposes a mental concept of gestalt (Tüpker 1988, p.48). Morphology sees this mental aspect as an entity that transforms the paradox of two opposing poles; a 'fixed', clear, limitable entity and a constant process of change.

Dahlhaus (1967, p.114) underlines this uniform character of a gestalt with the following words: 'Melody appears as a unit, as a compact process: the current final turn and the previous onset seem to be rather side by side instead of standing out against each other like a faded film.' Melody differs from a mere sequence of notes by its complexity and the graphic quality of its gestalt. The quality of its comprehensive shape not only allows for transposability but also in its perception may evoke feelings of comprehensiveness, wholeness and absoluteness, concepts that may gain significance as therapeutic categories.

The contemporary aesthetic concepts of melody also emerged from the attitudes and expectations of the nineteenth century, as we saw in Chapter 1. We still expect from a melody a certain originality and expressivity. In addition to evenness and conventionality, we expect an element of something new and extraordinary (Abraham and Dahlhaus, 1982).

Apart from melody shape, the parameters of harmony and rhythmicity today are seen as independent entities that play a significant role in the creation of melody and form part of the current concept of melody. A melodic analysis with a focus on the context will therefore address not only diatony but also the elements of rhythm and harmony.

It is an interplay between varying factors that become evident in definition of melody, in its elevation to a gestalt phenomenon, and in its cultural significance. Numerous examples in the musical literature show how the accentuation of one element has consequences for the others, so that the interplay of elements becomes evident in the musical movement. A primarily melodious piece of music may appear more complicated in rhythm than a mainly harmonious one. In combination with a slow pace, the emergence of a subtle, lyrical melody with core and ornamental notes may progress more distinctly than with a fast pace.

Melodies are manifold and therefore permit several systems of categorization and description (harmonic–metrically bound melody, unbound melody, vocal–instrumental melody, monophonic unaccompanied melody, polyphonic and homophonic melody, scale and triad melody, step and pendulum movement). However, it must be admitted that melody shape basically defies any compact

systematic representation. An assessment of its content of meanings will have to include its general musical characteristics as well as the occasion and purpose. These factors vary the melodic aspects in so many ways that it appears almost impossible to define rules, standards and criteria to evaluate a given melody.

For the purpose of analysis here, we must clearly differentiate between the spontaneous, immediate perception of a melody in the context of the situation, and an intended, focused perception that involves the written music simultaneously or consecutively in order to assess specific or several aspects. But how do we perceive a melody, and which aspects of melody are significant when we perceive its shape? Which aspects are most important for memory, and which evoke an aesthetic experience? These questions address the realm of perception that will be discussed in the next section with a focus on melodic elements. While we perceive the whole, the unity, this does not mean that the parts are superfluous for understanding, simply that we recognize when we are looking at the parts and when we are considering the whole.

## **On perception of melody**

We are taught that the influence of music, or of sound and vibration, comes to us and touches the senses from without; but there is one question which remains: what is the source of the influence that comes from within? The real secret of the psychological influence of music is hidden in that source, the source where sound comes from. (Khan 1988, p.73)

The experience of music is very difficult to describe. Many different approaches in musical analysis have developed as a consequence, as we will see later in chapter 4. The field of musical perception and perceptual cognition emerged out of a similar intention over the past fifteen years (Krumhansl 1996; Povel 1996; Schellenberg 1996; Thompson 1994). This development reflects the growing interest on the part of musicologists and psychologists to explore the cognitive and developmental fundamentals of musical perception and generation (Maier and Mies 1997). Various authors, of which only few can be mentioned, have attempted to research this field from different perspectives, that of philosophy (Meyer 1956; Meyer 1967, 1973), developmental theory (Krumhansl 1990), psychology (J. Sloboda, 1985), music theory (Cook 1994, 1995, 1998, 1999; Cooke 1982; Narmour 1992) and neurophysiology (Aiello and Sloboda 1994).

Despite the manifold comprehensive studies attempting to describe the basic process of perception, no satisfactory and comprehensive explanation of this complex process has been found so far (Aldridge 1996a, p.24). The person in the act

of perceiving and the object that is being perceived both form part of one and the same process. In this sense, perception has to be seen as a holistic strategy (Aldridge 1996a, p.24) that is not only reduced to cognitive perception but in its entirety refers to the deliberate act of experience, the awareness of music and the potential to play. Perception and action are the same wave. Perception is therefore an act of identity and a performance or, as Bergson claims, a virtual action (1896/1912). The concept of a discrete instant of time is an illusion and he uses melody to illustrate this point. Each note permeates the next, forming an organic continuity so at any instant we have the whole.

Cook (1994) pursues similar thoughts when he points out that many studies are based on experiments with auditory training strategies without reflecting on what actually occurs in listeners when listening to music; without exploring what they hear and why they hear something. His critique of psychological studies on cognitive perception specifically attacks the unilateral concentration on psychoacoustic parameters and the neglect of questions about personal significance and cultural value.

Dahlhaus (1967, p.117) also points out that musical perception goes beyond the mere registration of isolated acoustic data:

The detail just perceived does not exist alone but as one element of a whole that the listener is aware of in the mode of anticipation. While he perceives individual parts, his aesthetic interest that emerges and realizes itself through the experience of detail is already directed to the entire form, either partially or primarily, as a function of which we must see the details in order to achieve an unrestricted musical reality.

A particularist approach to understanding melody poses problems that emerge in the context of this study:

- Many studies on cognitive perception isolate their analytical parameters from the melodic–musical context.
- The comprehensive, burgeoning literature on music perception mostly refers to forms of passive music perception. There are, however, fewer studies that refer to the context of active music making, of performance. We have not been able to find any literature describing how a melody is generated within a musical improvisation between two adults. This may in part reflect a fact inherent in our civilization that most people listen to music instead of making music themselves. It may, however, also illustrate that, in scientific experiments that prefer a strict and close control of the situation to be analysed, it is easier to work with computer-generated

sounds compared to a less controllable, freer performance. But when the musical parameters that make melody are removed then we no longer have melody but a sequence of pitches.

### Arrangement of pitch sequences in groups

Melody is a musical parameter that is particularly easy to recognize and memorize. As already mentioned, gestalt principles are employed in psychology to explain the perception of a sequence of single notes as an integrated melodic unit. Some of those principles were defined originally by Wertheimer and Arnheim (Arnheim 1986) and are based on laws of visual perception, like proximity, continuation, similarity and symmetry. Considering a partial aspect of melody, that of diastemy or contour, then we may easily imagine how principles of perception may be successfully applied to explore melodic pattern. Certain pitch patterns become effective for generating and forming a melodic motif. The importance of the melodic contour is such that it is nearly impossible for us to recognize a familiar tune if its pitches are played in random octaves and the original melodic line is interrupted. We see this from the example of the 'Tarantella'. Figure 2.2a shows the unaltered melodic line of the song, while Figure 2.2b illustrates the altered version with octave transposition.



*Figure 2.2 Melodic line of the Tarantella: (a) unaltered, (b) with octave transposition*

This random transposition of single notes destroys the principles of continuation and proximity. Our recognition of a familiar melody increases the more notes are played within the same octave or within an overall order of ascending and descending octaves. To perceive a melody, we must be able to establish coherence between a sequence of pitches that constitute a melody. Thereby we group sounds in accordance with our individual, subjective, perceptual and cognitive organizational mechanisms. Various musical characteristics like timbre, rhythm, intensity and tempo influence our melodic perception. With a quickly played tonal sequence consisting mainly of large intervals, we tend to bring individual notes into more easily

perceptible, narrower range of continuous tonal sequences to achieve psychological coherence. This may often be observed in the perception of monophonic, polyphonic music (compare Figure 2.3) where sounds are perceptually segregated or separated as if they produce two different tonal lines; a higher and a lower one (Aiello and Sloboda 1994).



Figure 2.3 Tonal groupings to provide two different tonal lines (*J. S. Bach, Bouree from Suite nr. 3 in C-major for violincello*)

Moreover, relatively small distances such as half and whole tone steps in their sequence particularly affect the auditory attention (see Figure 2.4). Sounds of high pitch progressing in seconds are perceived as real and compact connection even if interrupted by other melodic events over a longer period (Blume 1989e, p.1349).



Figure 2.4 Connections between tones even if separated in time

It may be difficult for us to recognize or reproduce a melody exactly as we heard it. However, we might be able to recognize or reproduce the melodic contour that approximates the original melody.

## Melodic contour

Dowling (1994) defines melodic contour as the overall pattern of successive intervals that in their entire constellation make up the melody. The melodic contour illustrates how a melody moves up and down in the constellation of pitches and evolves in time. It is that musical quality which is most obvious for a listener. Music literature contains suggestions of how composers use this feature in the construction of pieces of music, making use of the aesthetic tension that results by repeating contour with altered intervals. An example (see Figure 2.5) is the first movement of Beethoven's Fifth Symphony – built out of a brief melodic motif and its sequence.



*Figure 2.5 Melodic core motif (Beethoven's Fifth Symphony)*

Motif and sequence share the same contour but differ in the size of the interval between the two pitches: the descending major third in the first presentation of the motif (four semitones), compared to the descending minor third (three semitones) in its sequence. This motif from which the melodic–thematic form of the entire first movement evolves is repeated over and over, appearing in different interval sizes between the two presented pitches, whereby the contour is always preserved. The repeated contour provides unity to the movement while the small intervallic changes with each repetition evoke interest and animation.

Another example of a repeated melodic contour with changes in intervallic detail is Bach's Fugue in C-minor from volume one of 'The Well-tempered Clavier' (see Figure 2.6).



*Figure 2.6 Repeated melodic contour with changes in intervallic detail (Bach's Fugue in C-minor)*

The importance of melodic contour for recognition of unknown melodies, heard for the first time, has been found to be an important factor in experiments that test subjective recognition (Dowling 1994). Test persons find it easy to respond positively to melodies with similar contours, and respond negatively to melodies with different contours. Moreover, listeners have far more difficulties distinguishing exact transpositions from same-contour imitations. It is particularly difficult when both melodies are in the same or closely related keys. This means that if two melodies (original and test melody) share both contour and scale they are easily confused, even if they differ in pattern of intervals. The difference between both melodies is perceived better if the scales are made less similar by increasing the key distance. Barlett and Dowling (1980) come to a similar conclusion when they take the process of transposition as a basis. Apart from the tonal characteristic, interval structures and melodic contour remain unchanged in the transposition of melodies. This has psychological relevance since listeners often are induced to perceive a melody as a transposition if contour and key are similar to the original melody.

Since melody appears as an integrated configuration, its contour cannot be seen as a completely separate characteristic. In the perception and memory of melodies there is an interplay between contour, tonality and rhythm. Tonality and rhythmic structure thus influence our ability to remember the contour. In our memory of melodies, the melodic line is connected with the tonal and rhythmic context. The parsing of a contour into phrases and the assignment of melodic accents depend not only on tone durations, on the rhythmic context, but also on accents arising from contour inflections (Drake, Dowling and Palmer 1991; Jones 1987). The close interaction between pitch and rhythmic patterns is particularly apparent when the same pitch pattern (and contour) is combined with a different rhythm, which may produce an entirely new melody. The song 'Die Gedanken sind Frei' may serve as an example to illustrate this idea. Figure 2.7a shows the onset of the original melody line; Figure 2.7b shows a change of rhythm with an unchanged pitch pattern.



Figure 2.7 'Die Gedanken sind Frei': (a) as original melody line, (b) with a change of rhythm but retaining the pitch pattern



Thompson (1994) points out that the pitch of a tone is better recognized when it is rhythmically accented than when it is not rhythmically accented. Conversely memory of melodies may be impaired when pitch structure and temporal structure do not imply compatible groupings. Laden (1994) also finds that temporal order influences what listeners perceive to be stable tones and anchor points in ambiguous melodies. Apart from the temporal structure, the respective tonal length (rhythmic component and articulation) has a specific influence on the perception of resolutions. These results support the notion that the amount of cognitive processing a tone receives is proportional to its duration. This might have implications for the representation of duration in models of music cognition.

Rhythm plays a significant part in music perception. Perception of language and music are demanding in that we must detect pattern. A listener must make sense of long sequences of rapidly changing elements being produced in time (Aldridge 1996a, p.30). This is easier for him if individual elements are bound by a time structure. The predictability of temporal structure is important for following a melodic line. Its connection with the temporal and rhythmic structure facilitates the perception of pitch and musical intervals as well as their integration into a progressive structure of musical patterns.

### **Pitch, timbre and tonality**

Intervals, pitch, timbre and tonality are the most significant characteristics for melody perception, apart from contour. It is difficult to define which of these characteristics is most essential to our ability to remember melodies. Hubbard (1996) points out that pitch is not a unidimensional stimulus corresponding only to audio frequency, but consists of at least two dimensions: pitch height (absolute frequency) and timbre (tone chroma, the relative location of pitch within a scale), which correspond with each other.

A similar definition of pitch is made by Christensen (1996, p.17), who sees pitch as a secondary aspect of timbre. His comments on pitch are as follows: 'Pitch is experienced as a certain height in a sound height continuum. This is a crucial phenomenon, evoking a vertical dimension of musical space. Pitch height adopts the nature of a spatial dimension in the perceptual processing.' He sees timbre as a superior aspect: 'The auditory perception of timbre is the general basis for the perception of musical tones, and pitch perception has to be understood as an aspect of timbre perception.'

The importance of timbre as one of the significant surface characteristics of melody is also underlined in a study by Radvansky, Simmons and Simmons (1995). In experiments on remembering melodies, non-musicians depend more on timbre (remembering melodies on the basis of the specific tone colour like McGuinn's



‘Rickenbacker’), compared with musicians who focus more on structural aspects in their memory.

From the perspective of music psychology, pitch – together with brightness and volume – is categorized as one of the subjective tonal components (Blume 1989c, p.492). On the basis of the listening experience, a tone is associated primarily with pitch, volume and tonal colour with reference to the physical correlates of frequency and intensity. Among all qualities, pitch alone has a constitutive significance for the note. In simpler words, the character (tonality) of a note may be determined from the basic qualities: pitch, length, intensity and tonal colour, whereby secondary qualities like brightness, hoarseness, sharpness, density and volume may provide further descriptions (Blume 1989c, p.496).

The qualities mentioned above also address the essential primary functions of our auditory perception – the perception of timbre, intensity and spatial perception (Christensen 1996, p.16). Timbre perception allows assessing and identifying of the origin and source of a sound. Pitch perception may be developed in a learning process on the basis of the natural perceptual potential. This process depends on the musical culture, which is characterized by the selection of favoured pitch levels and characteristic interval combinations. These are established as general conventional sounds through tradition.

In tonal melodies, the quality of tonality is related to pitch structure. Tonality plays an important role in our Western musical culture. It is easier for listeners to remember melodies if they are rendered in the diatonic system. The main key provides the basic structure to assign different pitches to the tonal functions and establishes their hierarchic interrelations (Krumhansl 1990). Key is one of the strongest binding forces through which listeners perceive coherence in tonal music. The most important pitch is that which corresponds to the tonic. Other tones gravitate towards the tonic that is considered the centre of stability. Many melodies start and end on the tonic, moving away from the stability and returning to it. Listeners perceive tones of the tonic, the dominant and mediant as those tones that fit best into a musical context (Krumhansl and Shepard 1979).

Bharucha (1996) also refers to elements of pitch height and the cognitive phenomenon of ‘melodic anchoring’. Melodic anchoring reveals the conditions under which notes are resolved. He proposes attention as a cognitive mechanism that drives the sense that a non-diatonic tone needs resolution. This psychological force is an expectation. It may evoke a conscious sensation of yearning for a particular resolution, as in the case of an *appoggiatura* or a suspension. Resolution of dissonance is a dynamic process requiring the formation of tonality, turning away from it, and return. Turning away, and returning, appear as typical musical processes like a kind of ‘mistake’ in the tonal design of a work of music. Bharucha (1994) also considers

temporal structure as important as it influences which tones in the melody are perceived as stable 'anchor points'.

The characteristic of the key defines a number of more or less expected pitch heights within the scope of its possibilities. If a melody fulfils this expectation on the part of a listener, then it is easier to memorize. The significance of tonal hierarchy and key is also apparent in the fact that such melodies are easier to remember if pitch patterns are located within the range of a fifth (Watkins 1985).

From a psychological perspective, the scale framework itself is understood as a set of various pitches, rather than as a set of different intervals (Dowling 1991). The dynamic tendencies of pitches that gravitate toward points of stability play a role in a tonal context. These dynamic tendencies are seen as characteristics of established sets of pitches rather than as characteristic sets of interval sequences. Intervals have less significance than pitches, and are easier grasped with reference to pitch patterns of familiar melodies. Intervals are more difficult to perceive and to sing when they are abstracted from a context of melody and key, compared with those that are heard as an element of a song. Adults can identify pitches better on the basis of interval relationship rather than on absolute pitch or tonal frequencies (Aldridge 1996a, p.30). Moreover, in a melodic context intervals are not perceived as intervals *per se*, but rather in terms of their position within the scale (Balzano and Liesch 1982). While Dowling sees the tonal structure represented in the form of sets of pitches rather than of intervals, Butler and Brown (1994) rely more on the informative content of intervals that indicate the tonality to listeners. In contrast to Dowling, these are among the most outstanding qualities in remembering melodies.

It appears that the assessment and understanding of intervals is handled in different ways in the literature on cognitive perception. Consequently, the following section will seek to clarify the theoretical significance of the interval as a first step.

## **Interval character**

From the perspective of music theory, interval (Latin *intervallum* = intermediate space) designates the distance and also the relationship between two notes ringing out subsequently (melodic) or simultaneously (harmonic) (Dahlhaus and Eggebrecht 1978). Intervals may be described quantitatively according to their distance (e.g. number of semitones) and also qualitatively with regard to their degree of sonance (consonance and dissonance). Physically, the ear evaluates the interval in its sequence of tones according to the pitch scale, the unit of which is the octave. The listener assesses an interval of two simultaneous tones according to the frequency scale, whereby the highest tone of the octave always has the double frequency ratios of the lowest. It thus follows the natural overtone structure (Blume 1989e, p.1326).

An interval, whether a melodic or harmonic, describes the concurrence of two notes that form a simple 'tonal figure'. The successive interval, the tonal step, is therefore the basic element of a melody or that of a tonal sequence with several parts.

### *Frequency and proportion*

The interval itself may be defined in three ways (Blume 1989b, p.1500): first, mathematically as the transition from simple to more complex numerical proportions; second, psychologically as the blending of steps (octave; fifth; fourth; thirds and sixths; whole tone; minor seventh and tritone); and third, physically according to larger or smaller number distance of coinciding overtones. This frequency ratio relates the frequency of one component tone to that of the other. For instance, tones of 200 Hz and 100 Hz have a frequency ratio of 2:1. The simplicity or complexity of numerical proportions serves as a symbol in this context and not as an explanation of the phenomenon.

The frequently voiced concept of an inherent, perceptual preference for simple frequency ratios – that is, a preference for consonances – is controversial (Schellenberg and Trehub 1996). Simple frequency relationships are of structural significance in Western music; therefore the universality assigned to them on this basis is often interpreted as ethnocentric.

Schellenberg and Trehub (1994, 1996) assume, however, that intervals with simple oscillatory frequency ratios have a natural or biological basis in line with suggestions from ancient and medieval philosophers. They substantiate this view with the customary occurrence of octaves (2:1) and fifths (3:2). While octaves appear to be musical universals, fifths are also structurally significant in civilizations like China, India and Java. In many musical cultures, melodic lines are accompanied with a drone consisting of the tonic (reference or key tone) and the tone a perfect fifth higher, reflecting the prominence of the 3:2 ratio. Schellenberg and Trehub demonstrated with their findings that infants younger than one year show preferences for simple frequency ratios (consonances) and that their perception of various tonal patterns with simple or complex frequency ratios (dissonances) are consistent with data from similar tests with older children and adults. The authors assume that human beings in processing tones develop predispositions for simple frequency ratios that are consistent with the dominance of musical scales with simple frequency ratios. This may be observed throughout history and across cultures. We assume that musical consonance not only has cultural origins, it is also a result of what we have learned to perceive as consonant and of how we have developed our perception of the spectral structure of speech sounds.

### *Closure and implication*

In the context of this study, it is also useful to mention Narmour's Implication Realization (IR) model (1990, 1992). Narmour's model is based on the idea that a small number of universal psychological principles effect listeners' expectancies of how a melody will continue. Accordingly, she regards the perception of melody as a function of a small number of universal principles that act in conjunction with style-specific factors. In this sense, her model describes the cognition of melodies as a series of closures, implications and realizations.

If an interval has no closure function then it may evoke implications in a listener. The gestalt principles of proximity, similarity and symmetry contribute to these implications. Since an unclosed melodic interval generates implications for the continuation of a melody, Narmour calls it an 'implicative interval'. Such intervals imply that some tones are more likely than others to follow. The interval between the second tone of an implicative interval and the following tone is considered a 'realized interval' that need not necessarily conform to melodic implications. Narmour claims that these melodic implications result from five perceptual predispositions, acting in combination with learned factors. She regards them as the five principles of the IR model: registral direction, intervallic difference, registral return, proximity, and closure. These principles are articulated in terms of pitch directions (upward, downward, lateral) and interval size, which are considered the primary parameters of melody.

Schellenberg (1996) points out that these principles of perceptual organization function in a way similar to that of visual organization. As an example of a strongly predictable factor for visual group formation he quotes the gestalt principle of proximity (compare 'arrangement in groups of pitch sequences' and 'characteristics of the current melody concept'). It is therefore not surprising that this principle influences the perception of complex auditory patterns, such as melodies in particular. The predominance of small intervals (proximate tones) in melodies across musical cultures supports the assumption that proximity is a universal principle influencing the perception and cognition of melodies. The significance of this principle may also (to some degree) be due to vocal production limitations, because small intervals are easier to sing than large intervals.

The principle of registral return describes a reversal of melodic direction and return to an earlier pitch range. It is a melodic archetype exhibiting proximate pitch relations between non-adjacent tones. Registral return also describes a pitch pattern that acts in symmetry with the temporal structure. Symmetry, like proximity, is an important visual factor, facilitating perceptual processing because of redundant information. Symmetry may therefore also be a basis of processing predispositions with auditory stimuli.

The principle of registral direction, indicating that a large interval implies a change of melodic direction, may be seen as a by-product of the proximity principle. A large interval in a melody violates the principle of proximity because it occurs between tones that are relatively far apart. Such non-proximate intervals might lead to a lack of melodic coherence. However, if a melody reverses direction after the large interval and the gap between tones of the large interval is filled in with smaller intervals, the inner coherence of a melody as a whole may grow (Meyer 1973). Figure 2.8 illustrates such a change in direction and is taken for the second study in this book, the 'Farewell Melody'.



*Figure 2.8 Melodic coherence and change in melodic direction*

## **Relationship between melody and harmony**

The concepts so far suggest that we assume everybody has more or less highly developed expectations about the progress of a melody and its harmonic sequence that are dependent on cultural context and education. These expectations are an integral part of listening to music and seem to play an important role in an expert appreciation of music and the evocation of emotional and aesthetic reactions.

Expectations, generated while listening to melodies, result from those features that are present in any melody – shaping of contour, pitch and pitch pattern, interval, timbre, tonality and rhythmic–temporal structure. Although melody in its comprehensive gestalt may be separated from its musical context as an independent component, it is at the same time a carrier of information of the various elements mentioned before that have to be processed perceptually.

When listening to musical sequences, we must be able to situate each sound event in relation to all others in the sequence. As our memory has its natural limitations and constraints, our perceptual system can deal with only a limited quantity of information at once (Drake and Palmer 1993). From the studies on melodic perception quoted here we may assume that, in relation to the natural limitations of our perceptual system, musical–melodic events are not immediately perceived directly in their entirety but instead are first segmented by listeners into groups of a size that can be analysed, and later the groups are situated in relation to each other. We have seen that different qualities like contour or timbre as outstanding characteristics may be significant for perception.

As already mentioned, listening expectations also refer to harmonic relations between individual elements of the tonal system. These relations come into existence whenever tones in a sequence are perceived as members of a specific key or underlying scale. These are then interpreted in accordance with both key and scale. Consequently, tones take on specific characteristics that determine expectations (Povel 1996, p.869). Thompson (1993) demonstrates that judgements of melodies reflect a sensitivity to possible harmonic accompaniments. The key context influences not only the judgement of a melody but also that of the harmonic material. He points out that under conditions of tonal stability, voices are integrated in harmonic sequences and the melody is perceived in its relation to both key and chord sequences. This substantiates the idea of unstable tones that move toward stable tones.

In general, we can speak of basic 'tensions' that exist between different tones. It illustrates the arrangement of harmonic expectations underlying and dominating our Western system of tonal music. Cooke's hypothesis says that the tension between tones originates from their relative positions in the harmonic series: the earlier a tone appears in that series, the more basic it is, and the stronger does it attract the following tones. Povel confirmed this in a series of experiments (Povel 1996). Similar ideas on tonal relations may be found in Zuckerkandl (1956, p.34ff).

## **Subjective perception of melody**

Despite numerous studies into cognitive perception of melody, there is still uncertainty about the factors determining the inner, subjective perception of melody. The earlier quotation from Khan (1988, p.73) alludes to this problem. What we can infer from external characteristics and external behaviour patterns does not explain conclusively how we process internally what we perceive. What is it that influences us from inside?

Musical perception, apart from and simultaneously with the perception of melodic elements and form, always involves emotions in listening. A listener in his individual emotional disposition reacts subjectively to the music. The perspective is therefore also directed to the emotional content of music. This refers to the expression and impression of music in the field of sentiments. Also involved are aspects like the expressive character of what is perceived and the effect evoked in a listener by expressive elements. The following section will explore this issue with a particular focus on the melodic aspect in more detail.



## Melody and expressivity

It is not experience that organizes expression but the other way around – expression organizes experience. Expression is what first gives experience its form and specificity of direction. (Volosinov, in Shotter 1996)

Expressivity is often seen as the object of musical performance (Palmer 1996). Not only musicians and psychologists, but also committed music enthusiasts and experts often voice the opinion that the beauty of music lies in an expressive deviation from the exactly defined score. Concert performances become interesting and gain in attraction from the fact that they go far beyond the information printed in the score. In his early studies on musical performance, Seashore (1938) discovered that musicians only rarely play two equal notes in exactly the same way. Within the same metric structure, there is a wide potential of variations in tempo, volume, tonal quality and intonation. Such variation is based on the composition but diverges from it individually. We generally call this ‘expressivity’. This explains why we do not lose interest when we hear different artists perform the same piece of music. It also explains why it is worthwhile for subsequent generations to repeat the same repertoire. New, inspiring interpretations help us to expand our understanding, which serves to enrich and animate the music scene. The Byrd’s definitive version of ‘Mr Tambourine Man’ brought Bob Dylan to the attention of a wider audience. Roy Orbison’s ‘Love Hurts’ has been the object of many cover versions since.

From a musician’s perspective, the choice of a certain means of expression is also a rational choice. There is a loose general agreement as to which notes within a melody or tonal sequence should be accentuated differently, and which not. We can compare various interpretations and explain why one strikes us as more appropriate than another. Obviously, this does not mean that there is only one acceptable interpretation, since interpretation possibilities are unlimited. There is no such thing as an ideal interpretation and performance, not in music and not in other arts (Palmer 1996). We may term a performance excellent when the artist succeeds in conveying his musical–structural concept to the audience. Expressivity is thus created as a function of varying elements, score-based information, artist’s interpretation and the listener’s interpretation. We may therefore presume that there are criteria according to which most musicians choose similar modes of interpretation as appropriate for a composition, on the basis of a common cultural background.

Even if we can speak of a common shared ‘language’ of expressive ‘rules’, this by no means implies a uniformity or sameness in performance. Sloboda (1985) points out that even within a rather tightly defined ‘rational’ expressive system, the potential for individual variations is still immense. A strictly constrained musical excerpt still provides many ‘free’ parameters: ‘We may suppose that the way which

different performers “fill in” these free parameters is what is responsible for their unmistakable individual style that permeates all their performances.’ Thus expressivity is no random, arbitrary option for variation chosen for a musical performance; it is mainly determined by the musical structures that at the same time provide a certain limitation.

The significance of modes of expression is therefore ambiguous and always depends on context. The expression of a melody is determined by its context and the underlying structure, comprising many different elements like pitch, contour, motivic aspects, interval structure, temporal–rhythmic design, articulation, dynamic properties, timbre and tonal structure. How these elements are categorized qualitatively depends on musical attitude and cultural background. The immediate feeling for what is melodically possible, in an organic sense, is both cultural and also individual. Therefore, we do not intend to describe the various experiments where musical intervals are related to certain fixed emotions.

### *Changes in timing*

Palmer (1996) reminds us that, apart from those expressive cues already mentioned, temporal asynchronization – such as retardation and acceleration in pace, dynamic changes and articulation – are frequently employed to present an expressively underlined melody. Dynamic accents are used to mark melodic contour or phrase structure. Rubato patterns and local tempo changes are other expressive features underlining melodic structure.

### *Beyond categorization*

Expressive features doubtless heighten the experience of a melodic gestalt. In active music-making, those features express the feelings of the person – offering an insight into the current disposition of that person. What is expressed and the symbol of that expression have a common logic. Expression, and its means of expression, are isomorphic (Aldridge 1996a, p.93). Emotions, however, are not necessarily located on the same level with states of excitation; they should rather be understood as expression of a person who knows about his or her own inner emotional life, even if he cannot name it. The temporal progression of an emotional state that becomes audible in chosen expressive features contains unlimited variation possibilities that have no common denominator. These ‘realities’ may go beyond the limits of conventional categorizations. In a world that seems to be increasingly coarsened, where the bigger, the louder, the more passionate is celebrated, then the subtleties of musical expression appear to be necessary. The advantage of this expression is that emotions need not be immediately lexically identified, they can also be subtle and soft like



tenderness. Furthermore, those emotional expressions also gain a form that may change within itself. As Langer writes, music has the unique advantage of articulating forms that cannot be illustrated and expressed in language:

Since the forms of human feeling are far more congruent with musical forms than with linguistic forms, music can reveal the nature of feelings in such detail and truthfulness that language just cannot compete. (Langer 1992, p.231)

## **Aesthetics and emotion**

Almost all cognitive insights involve emotions, and vice versa (Shiblis 1994). In the cognitive theory of emotion, emotion is closely related to the aesthetic, to perception, cognition and context. Cognition enables us to evaluate and assess the aesthetic value of objects. We learn and decide which experience is an aesthetic one. An aesthetic emotion evoked by a specific musical phenomenon is not only a physical feeling but is also interpreted. As an immediate, direct and spontaneous experience it always refers to present and past assessments. The musical event that evokes in us a feeling of joy may stimulate quite different aesthetic emotions at a later time and in a different context. Every aesthetic emotion corresponds to a different cognition (Shiblis 1994).

Sounds, in themselves, are neither good nor bad. They receive an external, objective attribute, so to speak, through our language alone that misguides us in this case. The term 'music' itself comprises a cognitive perception and evaluation of sounds that distinguishes them from noise – as every parent of a teenager knows.

Negative emotions like anxiety may be evoked by music (aesthetic emotion), but have to be distinguished from anxiety caused by situations in real life. Levinson comments on this aspect as follows: 'Negative emotional response to music is desirable because it conduces to mental health; it is safe' (Levinson 1982, p.328). If music or tragedy (in dramatic arts) help us to understand negative emotions and show their futility, then it can allow us to 'release' the feeling aspect of emotion so as to lessen our negative emotion and eliminate it also in everyday life. The point is not only to be released from this emotional aspect but also to change the assessment component, that is to find a change in one's own attitude: 'Jealousy is not eliminated by merely having a good meal or listening to relaxing music' (Shiblis 1994, p.379). If art leads us to a better understanding of negative emotions through an aesthetic understanding of critical, problematic situations, it might teach us a certain detachment from our own negative emotions and appreciate difficult situations in our daily lives as well. Problems and obstacles may therefore be seen as a chance to find new inner attitudes and to see adversity as a learning experience. According to Shiblis,

the aesthetic aspect has the potential to take the place or mitigate negative emotions and thus becomes a useful tool in therapy.

## **Cultural background and melody**

As we have seen, our understandings of melody are historical and cultural. These are evident in melodic forms from outside Europe that are based on improvisation and often have gliding transitions between notes. The tradition of Western art music culture, with the exact definition of each note in a tonal sequence, offers a form to be passed on as written music. Other cultures are based on an oral tradition, involving social customs and constituting clearly recognizable styles of their own (Brailoiu 1984).

The tradition of Western musical culture has led to creating abstract entities from the actions to which they refer. These are written down as entities. However, non-literate forms of expression are passed on by word of mouth and are embedded in rituals. They create their own styles and systems that are sustained and developed through successive performances over time. As circumstances change, the pieces change with them.

There is no criterion for melody that we can invoke that goes beyond the respective contexts of language and culture that will offer us a cohesive definition. Benzon (1993) discusses the cultural development of expressive forms and states that our basic musical experiences, like all our elementary experiences, are holistic. We first apprehend music undifferentiated as a whole, and only gradually get into a position to differentiate that overall musical impression into rhythm, melody and harmony. Only by the long process of cultural evolution has the awareness of the musical aspects – rhythm, melody and harmony – become increasingly differentiated and, thereby, under control. Benzon comments on this in saying:

Music unfolds in time. How could one gain control of melody without first having control of the temporal unfolding, of rhythm? And how could one have control of the simultaneous ordering of musical pitches – harmony – without first having control over the pitch patterns of individual lines that is melody? (Benzon 1993, p.279)

## Aspects of Music Therapy in their Contexts

In the first two chapters we explored the basic site of our search for the understanding of melody. But this site is also located within contexts of time, place and culture. When we talk about music and music therapy then we have to invoke varying contexts and influences that include the process of social change, technological innovation, the politics of healthcare delivery or institutional changes in educational needs. Our understandings are located within a cultural framework. Just as our practices have an ecology, so do our ideas. But a pluralist stance reveals a problem in a post-modern society. It offers us so many opportunities that we are in danger of seeing all things as relative and thereby losing orientation. We may indeed know everything about the contexts but nothing about the contained.

Irrespective of various music therapy approaches and methods developed from sociological concepts or those of humanistic psychology, music therapy has to be considered as a partial aspect of our healthcare culture. The hospital setting where therapy takes place in this book is located within a healthcare structure and within itself has a particular understanding of medicine. Furthermore, that medical culture also influences the ward sub-culture in which music therapy is practised.

Our healthcare system may be considered as a cultural process, comparable to arts and literature: 'health too is a cultural process and can be similarly subjected to an aesthetic critique' (Aldridge 1997, p.81). Cultural standards determine what is deemed healthy. People engage in activities like jogging, body-building or gymnastics and sports that serve as indications of 'becoming healthy' or 'staying healthy'. This reflects a modern trend in our society that concentrates on the generation of a specific definition of 'being healthy' by the individual instead of relying upon a definition imposed by others. While personal active involvement has always been

present in healthcare maintenance and prevention, in that people have strategies of distress management, a new development appears to be that being a 'healthy', 'creative', 'musical' or 'spiritual' person are considered to be significant factors in the composition of an individual's 'lifestyle'. Such a lifestyle is intimately bound up with how a person chooses to define him or herself (Aldridge 1997, pp.84–85).

Apart from health culture, hospitals that influence music therapy with their specific therapy concepts must be mentioned. Indeed, a progression of music therapy has been the recognition of music occurring in varying milieu as the movement known as Community Music Therapy (Ansdell 2002; Pavlicevic and Ansdell 2004).

Another aspect to be considered are the wards with their own attitudes, terms and procedures used to realize their treatment concepts. The data for both studies on which this publication is based have been generated in the context of such a ward setting. Study one in this book refers to work carried out on an oncology ward. Study two is located in the psychosomatic ward of the Herdecke Community Hospital. At that time, the manifesto of the hospital stated that its intentions were to: 'Support the sick person in realizing his individual abilities and, through his struggle with his ailing body, his fate and his environment, in achieving new ways to realize himself' (Rehm 1989). This holistic medical perspective understood that viewing the patient as a whole person is an essential part of medical treatment. Patients were seen as active partners in health care and not as mere recipients of therapies. Therapeutic and medical interventions were based on the principle that the individual determines the therapy process and has to be involved in what happens to him. Consequently, art therapy played an important role in such a comprehensive treatment concept. Apart from music therapy, there were also art therapies like painting, sculpturing, eurhythmics and language therapy. Clinical treatment decisions involved information from medical practitioners, nursing staff and the various creative art therapies. Art therapy diagnosis and documentation of progress made in art therapies played a significant part in treatment concepts. The creative art therapies were truly complementary in this context, both as a therapeutic community and as an early example of integrated medicine.

If we consider music therapy within the context of healthcare cultures, then music therapy is involved in various interactions in both a vertical and a horizontal ecology. A further network of relationships emerges when we concentrate on musical improvisation as the location of music therapeutic activities.

### **Improvisation as a core element in therapy**

Musical improvisation is a chance to prepare the ground from which a patient can develop her melodic expressivity. We use a 'musical language' that the patient can

understand. As artists, we make no sense when our works express something that others cannot understand. The dialogue with the audience conveyed through the work of art might turn out to be a one-sided monologue. Dialogue, as the basis of communication between patient and therapist, is decisive in therapy. It is impossible to develop a therapeutic dialogue if the expressive features within that dialogue are foreign to the patient. A precondition for an emerging dialogue is to perceive those forms of expression located in the patients' cultural milieu.

Improvisation is a basic element of creative music therapy, and also of the studies in this book. This improvisational approach was originally developed by Nordoff and Robbins (1977, 1986) for children with physical and mental handicaps. It was further expanded and developed with adult patients in various clinical fields at the Herdecke Community Hospital. We make the assumptions that music is an intentional human expression and achieves significance in its performance.

As an activity, improvisation is as old as mankind. All civilizations know and have known improvisation. The first musical material in human history required improvisation as a basis. In the musical life of some civilizations outside Europe, we still find the original unity between a creative idea and its simultaneous performance that in current Western musical life of today is often separated. Unfortunately, there are only a few systematic studies into improvisation. In ethnomusicology, and also in certain improvisatory forms of classical music, there are studies exploring – to some extent – improvisatory characteristics and models (Brailoiu 1984).

In 1938, musical improvisation emerged as a fascinating and prominent factor in ethnomusicology with the growing publication and acceptance of jazz music (Sawyer 1996). Traditional methods of music analysis turned out to be of only limited usefulness in describing improvisatory processes. Since most analyses focus on musical forms of Western music and its highly sophisticated notation system, analytical approaches are static and neglect the factor of unpredictability in musical performance. But it is this factor of unpredictability that is one of the most important characteristics in an improvisation and reveals itself in the very 'act' of improvisation; that is, in the immediate activity of inventing and performing music. In contrast to a composition notated in writing that gives a visual impression of the final result of a process of musical creation, improvisation is governed by a certain moment of unpreparedness, of spontaneity, and not solely by premeditation.

Two further characteristics of improvisation, the random element in a performance and the collective phenomenon of individual players influencing each other, are difficult to grasp and describe with linguistic, semiotic or structural models of musical analysis. In general, these methods turn out to be of no great use to explore the dependent nature of interaction in improvisation. Some recent publications in

jazz literature address the mutually influencing processes in group improvisations (Berliner 1994; Sawyer 1992, 1996).

There are parallel processes to be observed in linguistics, finding expression in arguments that challenge the validity of certain models of conversation analysis:

Although we are dealing with a structured ordering of message elements that represent the speaker's expectations about what will happen next, yet it is not a static structure, but rather it reflects a dynamic process which develops and changes as the participants interact. (Gumperz 1982, p.131)

In order to apply the structural characteristics of conversation analysis, a conversation would have to be treated like a static transcript. But such an analytical procedure would not take into account the ambiguity and indeterminacy actually present at each moment of interaction.

Another source of therapy-related improvisations are the improvisation models designed by Bruscia (1987) that give a comprehensive synopsis of various therapy models with improvisation as the primary method of clinical intervention. But there have been few publications so far of studies that have applied and tested his improvisation profiles.

Weymann also uses improvisation as a prominent tool in therapy that might – from a psychological perspective – trigger an involuntary restaging of a patient's problems in real life (Weymann 1990).

Lee (1995, 1996) gives an interesting insight into the analysis of an improvisation. He involves two levels, a macro and a micro level, in an attempt to design a formula to analyse therapeutic improvisation employing methods developed by Schenker and Nattiez. His concept focuses on the term of the 'generative cell'. Even if it seems plausible to use a biological–physiological metaphor to analyse clinically significant processes in music therapy, the choice of this term with the image of the single 'generative cell' implies not only a potential development but is also associated with the negative, expanding image of cell division characteristic of some diseases like cancer. In our opinion, the term fails to involve the essential aspect of dynamics in therapy that consists in the interaction between participants (patient, therapist). Cancer is the proliferation of cells that ignore the host environment and eventually kill the host. The generative cell only makes sense when it is connected meaningfully in its ecology. Thus the generative process must lie outside the cell. More importantly, the message to not generate further, and the messages about the form those cells will achieve, lies in the communication between cell and host.

Another variety of describing musical aspects of music therapy improvisations is suggested by Ruud (Ruud 1990a; Ruud and Mahns 1992, p.117) who proposes a four-step concept. This model is based on a phenomenological description of music

(according to Ferrara) and starts with an open listening period (as free as possible from preconceived expectations and attitudes), followed by an exploration of the musical material from several perspectives: a structural, a semantic and a pragmatic perspective.

A precondition for the application of musical improvisation in therapy in this book is the basic assumption that no previous formal knowledge of music is required in order to enter into the musical process. Playing techniques and previous knowledge will certainly make themselves felt in the improvisation; but in this context they are no criteria of artistic expression, as these become manifest only in the immediate musical moment. Improvisation may be applied on a flexible basis and thus permits active music-making on a level that is adequate and appropriate for both patient and therapist. We may therefore say that this type of active music therapy is based on the natural creative powers and abilities inherent in everybody.

Why is improvisation so fascinating and attractive in our musical culture, and why is it appropriate for therapy purposes?

Being able to improvise means being able to extemporize. And extemporizing has various definitions. It can mean to speak, or communicate without preparation. As we have seen, this is the spontaneous act of communication. It also has an element of a makeshift quality. This impermanence is vital to the concept in that nothing is fixed, form exists in the fleeting moment. Embedded within the word is the concept of being out of time – *ex tempo*. We have referred to this in earlier works as *kairos*, a decisive time in the moment, not the mechanical time of *chronos* (see Aldridge 1996a, 2004).

Spontaneity is advantageous in coping with a variety of life situations. To improvise means to ‘do something without preparation, impromptu’ (Drosdowski 1989). If we include the derivative from the Italian *improvvisare* and the earlier Latin verb *improvisus*, then we have both meanings of the unpredicted, the unexpected, the unforeseen, and meanings related to the foreseen (Latin *providere*). This implies the anticipatory component that plays a role in the cognitive system of perception and in the patient’s cultural context. Consequently, improvising is the simultaneous activity of inventing and performing music. Contrary to frequently voiced opinion, improvisation has nothing to do with licence, arbitrariness or inferiority (Blume 1989a, p.1093). Nor is it limited to music alone, but appears in all arts as an original form of creative expression. Each art form has its repertoires of expression and from these repertoires it is possible to perform spontaneously with improvisation.

The range of musical variations in improvisation is tremendous and certainly dependent upon the individual involved. Each musical parameter may be shaped in improvisation, from form-bound to form-free processes, or from amorphous phases to those executed with precision and decisiveness.



Musical improvisation allows us to make individual patterns of expression audible in a specific way. We may perceive it as musical movement, with not only an external component, like a clearly audible rhythmic structure, but also an inner quality. Inner quality addresses those moments in which the music-making person expresses his inner experience. The way in which he relates to himself, to his musical play and to the therapist tells us much about his individuality. This may express itself in a particular mode of articulation or the intensity of expression in a personal dynamic and temporal constellation. We can hear the emergence of 'spontaneous forms' and their further development in the musical process. The musical occurrences produced out of the moment may determine the direction of the musical improvisation. In the continuously emerging shapes we also perceive musical characteristics of the patient. In the process of expressivity, form is given to feelings and cognitions. We can enter into contact with patients on an emotional level without having to use a label for the emotions being expressed.

It is the role of a therapist not only to perform support and confirmation but also to offer impulses for change. An awareness of the currently occurring process and musical interaction is a necessary precondition to have a therapeutic effect. Even if we are not able to grasp the patient's musical experience in his current play completely (since we ourselves are part of this interactive process), it is nevertheless possible to see, from his musical material, his mode of expression and musical behaviour what he deems important and what he might wish to convey to us. A therapist aims to be perceptive all the time, to understand a patient's comprehensive musical utterances and to take them up into mutual music-making.

If a shape emerges in the course of musical improvisation, then we may not regard it as a fixed entity in the study of musical form, but as an individually grown external gestalt resulting from the previously 'spontaneous forms', motivic elements and musical events. The 'spontaneous form' may stand out autonomously from the musical structure as a melodic motif, and thus build a comprehensive gestalt together with other musical elements in the course of the improvisation. Form may also be used as a means of therapy, in the sense of a supporting structure (cadential formula, rondo or episodic form, variation form, ostinato form), as the platform from which the patient may realize her musical ideas. In therapy, form may provide an element of stability and security that makes individuality possible.

In jazz improvisations, musical pattern has a basis with similar significance. 'Being bound to a musical form reduces the number of degrees of freedom ... but not the creative exploration within the musical form' (Jörgensmann 1991, 914, p.27). Improvisation permits us to witness the entire creation process of the musical work of art in its gradually unfolding, individual shape, in 'statu nascendi' so to speak.



One important aspect that underlines the therapeutic significance of musical improvisation is that of communication. Ruud considers musical improvisation as a kind of 'proto-communication', as a general background for communication and interaction. From an aesthetic perspective, musical communication is an important way 'to define, differentiate, investigate, and point towards nuances in inner life, or stirring, so far not investigated areas in this landscape' (Ruud 1990b, p.15).

We can find further interesting suggestions concerning improvisation in practice and the processes involved in more recent publications on jazz. Berliner (1994) underlines, for example, the developmental change from imitation to assimilation to innovation. With the words of Walther Bishop he characterizes the successful process of individuation that may be influenced by various musical dimensions like vibrato, timbre, rhythmic and harmonic concept and their integration. In contrast to conversation, there is no sequential behaviour in jazz, apart from deliberately chosen dialogue. All participating musicians perform their own part continuously. Many jazz musicians nevertheless describe their interactions on stage as a kind of conversation:

I'd find that there are these things coming out of myself, which I didn't even know were there... Playing with the others triggers it, so maybe consciously or subconsciously you'll hear that thing, that you're trying to find... by listening to what other people have to say, and by talking to them about it, it's like talking about really great music, it's guys getting together and talking about how sad or lonely they feel, or how happy or angry. (Sawyer 1996, p.292)

This illustrates the highly communicative character of improvised music experienced on an emotional level. It is this experience of the immediacy and spontaneity of a message conveyed in a musical form (directed to oneself or another person) – through creative improvisation – that may have a more fundamental and liberating effect than a spoken message, the lexical content and form of which are limited.

As already described in Chapter 1, socio-cultural processes influence the generation of meanings. Active improvisation also involves us in a large variety of cultural values and standards. Against this background, musical improvisation with its flexible, variable character provides a good opportunity to react to, and address, the differing cultural backgrounds of our clients. Our book takes into account that both patient and therapist have probably grown up in Western music culture that, apart from contemporary developments, also has its roots in nineteenth-century ideas.

## Summary and significant aspects for therapy

The sounds of a melody do not act on us solely as sounds, but as signs of our affections, of our sentiments; it is in this way that they arouse in us the emotions that they express and the image which we recognize in them. (Rousseau in Scott 1997, p.817)

Langer (1992) considers music as a presentational, non-discursive symbol and we use musical improvisation here as an essential means of expression in therapy. The music therapy setting, as clinical context for both studies, involves the patient immediately in a musical experience. Aspects of perception, experience, action and production are performed mutually. Music therapy requires that a phenomenological understanding of perception must be applied that is isomorphous with the medium of music. Perception in this case means to have a nonverbal, qualitative, holistic awareness that is emergent with the phenomenon of music in the very moment of performance (Aldridge 1996a, p.24).

The element of the unknown, not predetermined, located in the future, plays an important part in the therapy concept. In the sphere of arts this unknown aspect is also a characteristic feature in the creative process: 'The function of art is to acquaint the beholder with something he has not known before' (Langer 1953, p.22). This aspect may gain significance in the healing process since this encounter with the unknown is the essence of illness. For the patient this is an excursion into insecurity accompanied by the fear of losing one's identity (Aldridge 1990). Patient and therapist both are involved in this encounter with the unknown, and both may make this experience in improvisation. Creative activity, however, allows us to do more than just expressing our pathology, it also enables us to express our potentials. We can literally play with future aspects of our being suggesting positive possibilities and ways for development. As anticipation is invoked within the playing, the future is invited into the present. Rather than the sick person, we have the competent performer. Such creative agency, in mutuality, is the basis of being an empowered human being.

Between perception and experience, we find that which is produced, the actual material of performed music. In order to investigate the improvised material it has to be treated like a gradually emerging product of art of which a transcription can be made. Only on this level, a level already removed from the actual activity, can analytical evaluations of the played and notated musical material take place. The experiences of immediacy and expressivity can only be evaluated and assessed vicariously but we cannot expect here an exact definition of what takes place. We can hear performances, but translating them into a visual or textual modality is difficult.

The focus of the research presented here is the moment when melodic development takes place. On the basis of two studies, we attempt to discover the processes in the development of melody that occur during music therapy sessions within a hospital setting. We will also try to suggest what the therapeutic significance of this developmental process may be for patients.

There are manifold musical aspects involved in the process of generating a melody. There is no point in concentrating on rules, regulations or normative melodic constructions when analysing the improvised musical material. Instead it is important to concentrate on melodic events and attempt to catch the effect of how they act in combination. These elemental events, coming out of the patient's creative process as something new and consisting of rhythmic and melodic motif, may have a connection to harmonic structure and dynamic variables in the music. The following analytical criteria will be important for the assessment of melodic improvisation:

- formation of certain intervals and specific pitch patterns
- existence of a rhythmic motif, that could have a stabilizing effect
- existence of a melodic motif
- further continuing progression of the rhythmical–melodical motif towards an organic entity, through imitation, assimilation or innovation
- integration of the musical–melodical elements in the patient's playing
- formation of melodic contour, phrases and periods in relation to harmony (to the qualitative distribution of intervals)
- expressive personal statement of the patient via musical–melodic elements
- articulation and musical expression including all dynamic and tempo-related nuances
- musical interaction between patient and therapist.

For the therapist this implies the need to observe again and again, and to be able to continually look afresh on the musical material, to discover the particular and special way patients choose to express themselves in finding their own appropriate form of expression. If melody reflects expressivity, and this relieves suffering, then the therapist is advised to pursue the development of melodic motifs. As these motifs are based upon rhythm and harmony, to maintain expressive form, we have to consider the musical improvisation as a whole. To develop melody then, a substantive harmonic and rhythmic base has to be present.

Several instruments are used for the two studies here in addition to the piano. These include the metallophone, xylophone, wood block, chime bars, glockenspiel,

marimbaphone and vibraphone. By the horizontal arrangement of the individual tones of these instruments, there is preordained playing movement that correlates with spatial tone distances both small and large. The very spatial structure of the playing surface influence the perception of successive tones to spatially imaginable distances.

From a musicological perspective, focus is usually made on the completed, finished work of art. In the context of therapy, this perspective is significant only insofar as it provides musical parameters to describe the musical material as presented. The principal focus in therapy, however, is on the process – making music – rather than the music made.

## Search for the Appropriate Method

Any study is only as good as its method. As yet, we have no established procedure for analysing melodic improvisations, particularly therapeutic improvisations. So it is important to find a way of looking at music therapy improvisations to see what happens when two people made music together and how that music-making is related to the development of melody.

Both studies described in this book are based on individual melodic improvisation developed jointly by patient and therapist within a recognizable musical context and both have a specific therapeutic relevance. We make no attempts at generalization but the reader will make his or her own conclusions. Either it makes sense or not. That is the activity that the reader brings, we can only try to describe what happened retrospectively.

Since the musical process developed jointly by patient and therapist may be experienced as intimate, an analysis of such processes demands that a dimension of subjectivity is included in the analytical method.

### Research

Knowledge is something that can be done, it is a creative activity, a process not a fixed product. Once we take such a position of knowledge being actively acquired, then we can speculate upon the various arts of doing science. (Aldridge 1996a, p.7)

Starting out on a search is an exploration and may best be described by the English word 'research', derived from *recerchier* in Old French which means to 'inquire, investigate, search for again'. The corresponding German verb *forschen* is derived from the words *vorschen* (Middle High German) and *forscon* (Old High German), also with the

meaning 'ask, inquire after'. If we go back further to the Indo-German origin, *per(e)k*, we also find the same root to 'ask for' or 'request'. We also have the addition of the prefix *erforschen* (Middle High German *ervorschen*) (Drosdowski 1989). With regard to this study, this means: *We will investigate what happens in therapy and search again for the meanings that it holds for the researcher.*

These linguistic meanings are of further relevance to this study insofar as they remind us of the process itself that reveals a path of discoveries and explorations through continuous and repeated re-search – searching again. Science is a process, an activity that is not constituted as a set of commandments set in stone for all time as the basis for a dogma. We could call it 'sciencing', but that again resurrects the clumsiness we have tried to avoid in the introduction.

The arts and sciences are the important aspects of our culture necessary to express human life. Both lead to an awareness of form and expression. In a search for 'meaning' in research, the media of presentation may be artistic as well as scientific. Both are activities that create knowledge – we literally 'do' both art and science. This means that we can move away from the Cartesian position 'I think therefore I am' to one that suggests 'I perform therefore I am'. The advantage from this perspective is that both body and mind are integrated in knowing. And, knowing itself is a performance subject to change and open to improvisation.

Varying definitions of the term 'research' (Drosdowski 1989; Makins 1991; Partridge 1990) suggest the discovery of something new, and also a change in an originally common perspective of things. Bruscia defines 'research' as 'a systematic, selfmonitored inquiry which leads to a discovery or new insight, which, when documented and disseminated, contributes to or modifies existing knowledge or practice' (Bruscia 1995a). The quotation comprises the following components:

- *Systematic procedure.* This presupposes that a researcher needs a focus or research question on the basis of which he looks for an appropriate method for his research project, which has to be formulated and organized accordingly.
- *Self-monitoring.* To be self-monitored means to observe continually and manage and prove all factors that affect the ethical and scholarly integrity of the inquiry.
- *Explorative process.* The researcher has to collect data and to organize information but also to reflect upon these in order to gain new insights. Research therefore goes beyond mere data collection and incorporates both reflection and discovery. The various forms of data analysis, like statistical, logistical or aesthetic data analysis, may be reflected upon, and

this may result in the discovery of new insights, understandings and perspectives and give access to new levels of perception.

- *Contribution to theory and practice.* The results of the research project have to be documented and disseminated in some way, in other words, published; otherwise they would be nothing but personal insights. Consequently, research has by its very nature a more public and collective component and not so much a private and individual one. Research findings, in whatever format, should be documented in such a way that they are communicable.

This quotation may be complemented as follows: The system of self-monitoring in the explorative process is important and may lead to new insights. This means that not only the results of research but also both the research method (its process) and the research results (its product) are important. Both reflect the therapy situation where the therapy process reveals – or brings to light – just as much as its therapy outcome. We refer to this aspect as the ‘reflective practitioner’, constantly inquiring into what he or she is doing. From this stance we can unite both research and practice.

## **The situation of research in music therapy**

To fall within the boundaries of discipline research, the topic must include these four elements: the client, the therapist, the musical experience, and the therapeutic process. (Bruscia 1995a, p.26)

Research studies in music therapy (Aldridge 1993a; Bruscia 1995b; Ruud and Mahns 1992; Töpker 1990; Wheeler 1995) demand an awareness of the meta-critical dilemma in which a researcher finds himself, because music therapy is interdisciplinary and influenced by the fields of music (systematic musicology), medicine (natural science) and psychology.

The methods we use in research are influenced by the philosophy of science (Aldridge 1996a). The controversial issue of epistemology and theory as a basis for research, and the pertinent methodologies, are discussed specifically by authors such as Aigen (1995, 1996), Aldridge (1993a, 1996a), Bruscia (1995b, 1995c, 1995d), Ruud (1990a; Ruud and Mahns, 1992), Smeijsters (1996), Töpker (1988, 1990) and Wheeler (1995).

There is a debate between process-oriented and result-oriented research, closely related to the issue of economic efficiency in music therapy (Aldridge 1996a). The latter affects music-therapy research projects insofar as general cost-cutting efforts in the healthcare sector have resulted in a focus on demonstrable clinical results. This

sometimes goes under the guise of evidence-based medicine, the original intentions of which (to improve practice through research) have been perverted through an emphasis on practices only verified by research from a limited base. Such external issues affect research activities not only in music therapy but also in other areas of healthcare delivery, education and social welfare all over the Western world.

Because music therapy is interdisciplinary, there is a wide and manifold range of research questions and approaches that influence the various scientific approaches considerably (Ruud and Mahns 1992, p.136). Their methods form part of a comprehensive general research concept that is applied to the specific needs of music and music therapy. Many research concepts in music therapy – e.g. in the fields of social sciences, psychology, educational sciences (compare Heal and Wigram 1993) and sociology – emerged as a consequence. It is only natural that various trends produce similar basic questions for which, however, a different focus is applied in each case. The book *Music Therapy Research* (Wheeler 1995) provides a good survey of the many new research techniques that have been developed continuously in related disciplines.

Despite the tremendous divergence and variety in this field of research we should keep in mind that there are unmistakable, specific characteristics in music therapy: music, and the musical relationship evolving within the interpersonal context. Bruscia (1995a) therefore suggests that we narrow down research in music therapy, to specific issues through a clear definition of the following aspects: music therapy, music therapy as a discipline, music therapy as an occupational area, music therapy in practice, and music therapy and theory. This concept is briefly described as follows:

- Bruscia defines music therapy in the form of a synthesis of already existing definitions: 'Music therapy is a systematic process of intervention wherein the therapist helps the client to achieve health, using musical experiences and the relationships that develop through them as dynamic forces of change' (p.17). Four elements in this quotation are considered essential: the client, the therapist, the musical experience and the therapy process.
- Music therapy as a discipline is mainly concerned with the process by which therapists use music to help clients achieve health. Research issues in this field focus on the question as to how music therapists interact with patients in using music for therapeutic purposes. The client is at the centre of this research.



- Music therapy as a profession refers to a professional association that organizes its members in order to integrate theory and practice. This means to exchange on practical work with one another and with other professionals, along with the socioeconomic, political, and educational conditions affecting the discipline of music therapy. The purpose is to share experiences, to apply findings and to encourage projects. Here the focus is on the music therapist.
- Music therapy in practice involves three different perspectives in clinical research: working directly with the client; observing one's work with the client; analysing these observations of one's clinical work for research purposes. Clinical work comprises action, reflection and meta-reflection.
- Music therapy and theory formation are related in research insofar as theory has to offer a number of related principles and is able to organize and clarify what has been learned through research or practice. There is a great number of different types of theories that are always dependent upon the respective focus in research. It is, for example, possible to form theories that synthesize different aspects of clinical practice and research.

Bruscia's perspective can also be applied here. The focus of the research here is located within the boundaries of music therapy discipline and practice, since its current research topic involves the four elements 'client, therapist, musical experience and therapy process'. It also involves the observation of therapy work that offers insights into melody development in the therapeutic process.

## **Subjectivity and objectivity**

The therapy form used here includes a subjective dimension, since the researcher as a therapist is personally involved in, and subjectively experiences, the musical process developed jointly with the patient. It is therefore pertinent to reflect upon the terms 'subjectivity' and 'objectivity' that are frequently discussed in literature.

The important point is to find one's own position among the manifold disciplines influencing the field of music therapy. Questions emerge that involve the integration of distance and objectivity in a therapeutic setting. Smeijsters (1996) points out that 'objectivication' within this setting means to limit oneself to what everybody may perceive without empathy and interpretation. He thus refers to the epistemology of objectivity as recognized in positivistic research, which within its context has come to be acknowledged as the appropriate method of analysis and assessment, directed at the nature of facts and mainly free from subjective additions. He adds as criticism, however, that this procedure limits perception considerably so

that questions arise as to whether objectivity can be the most important issue and whether it is actually feasible in a therapeutic setting.

Another core issue to emerge from this problem is how to change over from the previous role as a therapist to that of a researcher. In literature this role conflict is generally mentioned as one of the possible dangers if research is carried out in a familiar setting (Schutz 1993), as the research described in this chapter was.

To take up the function of a researcher, however, does not automatically imply that one has acquired the characteristic of objectivity. Being human, whether as a therapist, researcher, or colleague, always involves subjective emotions in each of these roles and must be accepted as fact. We must not overlook the risk that egocentrism and a researcher's subjective attitudes can affect the findings (Bruscia 1996).

However, we do belong to both communities of inquiry and communities of meaning. The language that we use and the very ideas that we have are part of a shared cultural basis that we have with others. The ecology of ideas that we share influence the conclusions that we have available to draw upon. This is not a deterministic position, but argues against the total individuality of solipsism and can be countered by a constructivist argument: we share a commonality although individually interpreted.

A researcher's subjectivity cannot be denied, as a researcher committed to his work cannot and should not become separated from individual experience and personal perspectives. Schutz (1993) characterizes a researcher's relationship to his subject matter as mutual and dynamic, where the researcher as the agent brings his research material 'to life' and interprets it.

Therefore, an exclusion of personal conviction as part of the research setting cannot be very effective. The point here is not so much the debate about subjectivity or objectivity but rather a general recognition of a researcher's subjectivity, an acknowledgement of her personal values and acceptance of her prejudices and opinions as a natural consequence of her social and cultural context. This means that such a research approach does not endanger the validity of the research.

But before we can achieve clarity of purpose and find a research focus, we must achieve clarity with regard to ourselves, as therapist and as researcher. If we do not wish to deny our being human in the capacity as a researcher, then we will have to explore our inner self for our specific values and ways of thinking. The questions we must ask ourselves are: What are the paradigms of the philosophical concepts we subscribe to? What is the social and cultural context of our reflections and activities? What is our understanding of what it is to be human? What is our perspective of illness? How do we define the professional aspect of our therapeutic activities with

regard to our personal values in general and in particular? What are our preconceptions (Bruscia 1995b)?

As a consequence, we are faced with this question: *What kind of method can help me to reveal my personal subjectivity that influences the development of melody in the therapy process?*

After analysing my own position, I can then attempt to apply various models and methods of scientific theory to my personal and professional context. The phenomenon that emerges with the essential research question is the starting point for the research idea and the basic motivation for the first step that – if necessary – organizes various methodological ways to reveal and resolve this phenomenon (Bruscia 1994, 1995b).

In this study the phenomenon appears as the process of the emergence of melody, as the development of a melodic form within music therapy, triggered by individual qualities in the patient's and therapist's music. This brings up the essential questions: *In which way and under which conditions does a patient develop his/her individual melodic form that provides emotional expressivity? In which way does the therapist introduce her melodic form into the therapeutic process?*

## References to basic phenomenological concepts

In the context of the subjective aspects of a music therapy setting, we refer to phenomena as happenings, events, experiences, particularities or unique qualities that we experience in contrast to theoretical knowledge. An example is light. A phenomenologist would base understanding of light on how light is immediately experienced by a subject as bright, shining, warm, comforting, calming. A natural scientist would understand and explain light as a wave equation (Quail and Peavy 1994).

Phenomenologists assume that all things start with the world as experienced, the world as it is lived and perceived before it is abstracted into theory or explanations. Experiences are a fact in our world; they exist and therefore do not have to be categorized as true or false, valid or invalid. They are worthy of investigation simply because they exist (Forinash 1995).

In order to understand these human experiences, phenomenology uses a method that is discovery-oriented (identifying how phenomena are given in experience) and offers a way of explicating the essential qualities, structures and forms emerging from the experienced phenomena. The starting point is not a specific theoretic perspective but the lived experience. It is possible to become aware of a lived experience, to describe and thus reveal it and in so doing share and compare that experience with others.

We can accept experience as a perspective of our scientific activities and involve subjective data as a starting point. We do not have to restrict ourselves to limited inquiries and so-called objective procedures in the sense of a physical or technically conveyed world of data. Understanding and cognition do not result from a distanced attitude alone. There are also times that demand cooperation, when identification with the other is essential. Awareness consists of the observer, the observed, and the experience of observing. This experience will always affect the researcher as well.

In the tradition of European phenomenological philosophy 'Being in the world' is a clarity of vision and revelation, as a unified experience. Hence, we emphasize human existence as a 'performed reality' that is not separate from the world but actively committed into it.

In the phenomenon of music we see a qualitative, nonverbal and participatory holistic awareness. In listening to music, the phenomenon becomes its own explanation: it is that which shows itself in itself. Therefore we can perceive human beings as they come into the world as music; that is, physiologically and psychologically composed as a whole. In using a musical metaphor, we offer a perspective that proposes personal identity as a musical form, which is continually being composed in the moment. This is in contrast to a mechanistic perspective of being that is concentrated on the body as something to be 'repaired' with pertinent therapies. We are not constructed mechanically. We come into the world as intentional, biological, psychological and social organisms that have to be improvised continuously in order to meet the internal and external challenges of daily life. Even on the cellular level of our immune system, our identity is an active system improvising each moment anew in order to be prepared for all eventualities.

The close relationship between the phenomenon and the structure of human consciousness also refers to the term of 'intentionality' as used in phenomenology. Intentionality is a term of central significance in recent philosophy (Husserl 1968).

## **Intentionality**

The term 'intentionality' has a long philosophical tradition and was pointed out by Brentano and Husserl as located at the core of mental–spiritual life (Spielberg 1936).

Objects cannot be explored independently from the consciousness that beholds them. There is a mutual coexistence between the subjects and their world, a necessary unity that is in contrast to a natural scientific perspective toward subject–object dualism (Quail and Peavy 1994). Intentionality, therefore, forms the essence of consciousness and is directed toward something that is not consciousness itself or that is beyond the conscious act to which it relates, such as memory or an immanent object. There is a tension and stretching between object and conscious-

ness. An idea is always an idea of something (Vedeler 1994). Becoming aware may express itself through the creative act in music therapy. Consciousness becomes then not a matter of 'I think that' but rather a matter of 'I can' (Aldridge 1990). 'I can' is an important element of intentionality that cannot be measured but can be heard and demonstrated. The significance of this term is relevant to this study since we will be seeing how the participants signal their intention to play together in the music.

Originally, in the Middle Ages, intentionality had a specific meaning in medicine related to the healing properties of the body. When a soldier was wounded, physicians observed that the wound would also heal by itself. There is a natural mechanism in the body dedicated to maintaining the integrity of the living organism. That physiological intentional mechanism of regaining coherence was termed 'intentionality'. Moving beyond the physical body, we can take a holistic perspective and propose that there is a process working on all levels to maintain coherence and music therapy provides the non-material time structure for intentionality.

## **Elements of phenomenological research**

Phenomenology as a research method has its origins in phenomenological philosophy and, accordingly, has a rich, comprehensive and in-depth history. As a method it allows for investigations into complex phenomena and offers an opportunity to explain essential qualities of art therapy phenomena in the way these are experienced by clients. This is why psychologists, artists, art and music therapists, nurses and caregivers often take up ideas from phenomenological philosophy in their research projects and apply them to human experience (Forinash 1995).

It is this research area in particular (Beck 1994a, 1994b; Quail and Peavy 1994) where phenomenology as a method may show us a way to understand how consciously experienced phenomena may be described without theories about their cause and as free as possible from unexamined preconceptions and presuppositions. The researcher herself constitutes the main tool for data collection. She is not free of bias. To expand her awareness, she must stand aside and acknowledge preconceived ideas to rediscover the perception of a lived experience. Beck (1994a) underlines the aspect of experience in quoting Merleau-Ponty, who considers 'astonishment', on the part of the researcher, when faced with the lived experience, as indispensable to describing it. Similarly, Smith (1979) sees the lived musical experience, and the musical phenomenon itself, as an important and essential reality within the historical tradition of musicology.

A researcher will never be able to free herself completely from preconceptions in reflecting upon the experience to be analysed. However, she will be able to control

them. Beck makes some comments on this aspect in her study; she suggests asking oneself repeatedly in the course of the study what one sees as evident, or to ask whether the phenomenon was experienced actively or passively. Another possibility, she mentions, is to make journal notes in which a researcher can reflect upon personal feelings and make explicit her beliefs, bias and assumptions. Self-questioning can help to maintain a heightened level of awareness throughout a research project and thus expand the researcher's experience in the course of the study.

The phenomenological method is particularly appropriate in creative music therapy since it enables us to understand a client's experience in music therapy. The first step is not to concentrate prematurely on interpretations and thus to risk losing sight of the phenomenon itself, but rather to give exact descriptions. Audiotapes of recorded music therapy sessions may serve as a basis that can be transcribed and listened to, or read, repeatedly. The musical text may contain hints on therapy processes and changes of possible significance for the entire therapy course. The phenomena revealed in the musical text that has assumed significance may be categorized and lead to the discovery of specific issues in the therapy process.

When we attempt to discuss specific issues in therapy, we must keep in mind that therapy discussion is always several steps removed from the patient's and therapist's artistic activities themselves. Aldridge (1996a) draws attention to this fact and proposes three different levels that lead away from the actual activity of doing therapy. These must be taken into account when we talk about therapy:

- *Level 1: Experience*, where the phenomenon is experienced. It lives and exists in that moment, but is only partially understood. Therefore it cannot be wholly reported. We can see, feel, smell, taste and hear what happens. These are the individual expressive acts and are known in modern linguistics as 'parole'.
- *Level 2: Description*, where we discuss the therapy situation including the particular terms of our artistic disciplines (colour, patterns, movement, motif, theme). Descriptions are relatively objective and accessible to verification (tape recordings). They correspond to the mutual, shared element of language, the usage, that is available for systematic study and is part of our common everyday discourse.
- *Level 3: Interpretation*, where we articulate the underlying abstract ground within language: 'langue'. In order to explain what happens in music therapy, and to say what the relationship is between the activity and the process of healing, we must grasp and transpose musical changes into terms of the academic disciplines of psychology and psychotherapy, or



transfer them to a medical system. On this level the therapist is involved in interpretation and is thus removed further from what has happened.

At the level of performance (level 1) what occurs in the therapeutic session exists for itself. Everything else is an interpretation and depends upon language and it therefore imposes its subject–predicate grammar upon a dynamic activity.

However, we do need to talk to each other about what happens and what we do. The second level, ‘usage’, offers an opportunity to find a common language for therapists interested in exchange, which is based upon descriptions of the artistic process and thereby closely related to the therapeutic activity as such.

Frequently there is a risk that we describe the therapeutic process at level three, that of interpretation and inference. This may lead to vague statements and a loss of conceptual coherence.

## **Hermeneutic phenomenology**

The categorization into three levels brings an awareness of the level of interpretation we are acting on. The levels locate the hermeneutic phenomenology in the centre of our considerations. The word ‘hermeneutics’ comes from the Greek word *hermeneia* or *hermeneuein*, which means ‘to interpret, to explain’. The Greek root of the term reveals that understanding details and specifics involves the process of language. In contrast to the explanatory method of natural sciences, the hermeneutic method attempts to understand utterances and works of the human spirit – including works of art and texts of many types – and their contexts (Brockhaus 1984). Hermeneutics may be considered as an academic discipline that, in the course of its history going back to antiquity, has developed a theory of interpretation exposition through a reflection on the circumstances of understanding.

The activity of explanation starts already on the level of perception where what appears empirically has to be perceived in a way that is as differentiated, concrete and literal as possible. To understand what a text means, in hermeneutic phenomenology, is to understand one’s own self in a kind of dialogue (Koch 1994). This means that there is a dialogue not only between the researcher and the text but also between the reader and the researcher’s interpretations. Our assumption is that both researcher and reader bring to the analysis her or his own preconceptions. This kind of dialectic interpretation is open for reinterpretation since no-one expects readers and researchers to share the same opinion (Annells 1996). However, a researcher must demonstrate to a reader which path has led him to his interpretations, thus enabling the reader to follow the arguments proposed by the researcher or author. Accordingly, dialogue is the source of understanding in conversational hermeneutics, not the logic of the statement.

In this context, we would also mention the relational aspect of interpretation with its relevance for psychological interpretation (Bovensiepen 1995). Interpretation and relation form an inseparable unity. According to Jung's perspective of dialectic procedure, a successful interpretation with therapeutic efficiency does not presume a unilateral interpretation on the part of the therapist with a subsequent, secondary rational understanding; but rather, it presupposes a mutual discovery of meaning, a joint effort of understanding and ultimately an agreement as a product of this joint effort (Schulz-Klein 1997).

Hermeneutic phenomenology searches for understanding and not for theory. It is directed against the Cartesian view of the world, against Cartesian duality with a perspective that separates body from spirit (Annells 1996). The focus is on ontology instead of epistemology. Meanings, and their interpretations, are performed as a dynamic activity. And, if they can be performed, they can also be mutually improvised in the moment. Such ideas when they are written down are simply fossil traces of the process of performed thoughts. Indeed, we can say that performing music as expression is itself the explanation of an inner understanding and that the concept of hermeneutics has been all too often predicated on verbal language, when musical expression for many of us is the only 'explanation' that we need. It is only when we come to communicate to others in a written form that we need to shift from a musical mode to a lexical mode.

The close connection to the phenomenological approach is significant to this study since we are not searching for a universal elusive truth here but for the significance and relevance of musical phenomena based on particular experiences.



# Therapeutic Narrative Analysis: A Methodological Proposal for the Interpretation of Music Therapy Traces

The difficulty we face in clinical work is how to analyse the piece of work that we have before us using a systematic procedure that has therapeutic and clinical validity, which remains true to the art medium itself. If we wish to discover how a particular creative art therapy works, then it is of paramount importance to maintain a focus on the work using the material traces of that work. What we need to develop is a means of discerning at what level we are describing, or interpreting, the traces before us. In this chapter, we present a method for analysing trace texts suitable for music therapy research that is not bound to any particular music therapy orientation and that can be applied to other creative therapy orientations. Thus for music therapy research we may use recordings, transcriptions as musical scores, transcriptions from interviews as texts, and some may indeed use drawings. In this sense, the method proposed is retrospective although the approach can be used prospectively.

We are concerned with performance in therapy. We also refer elsewhere to health as narrative performance (Aldridge 2000). This has led us to the research method that we now call Therapeutic Narrative Analysis. It is intended as a method for the creative arts therapies and has been developed from previous writings about therapy (Aldridge 1985, 1988a, 1988b, 1990, 1991a, 1991b, 1992a, 1992b, 1993a; Aldridge and Aldridge 1996, 1999; Aldridge and Brandt 1991a, 1991b; Aldridge, Brandt and Wohler 1990; Aldridge, Gustorff and Neugebauer 1995; Aldridge, G 1996), and from working with doctoral students during their various methodological quests.

It is a flexible form of research design, and may include quantitative data. At its heart it is hermeneutic; it is based on understanding the meaning of what happens to us in the process of therapy and how we make sense of the world. We refer here to 'us': researchers, therapists and patients. The choice of the term 'flexible design' is used here as the tiresome debate about quantitative/qualitative methods has been superseded with the terms 'fixed' and 'flexible' methods, a concept much more applicable to clinical practice researching (Robson 2002).

We choose to use 'narrative' here as this is a broad concept well suited to research in music therapy. Central to the narrative methodology presented is the idea of episodes (Aldridge 1998; Harre and Secord 1973). An episode is an event, incident or sequence of events that forms part of a narrative. Taken from the Greek *epi* (in addition) and *eisodios* (coming in), we have the notion that it is something that is added along the way (*eis* = in and *hodos* = way, road or manner). Thus therapeutic narratives are composed of episodes, and it is episodes that we will consider as the basic units for our research methodology in the following chapters.

When we chain understandings together to make a story or a case history, then we are composing a narrative account. When we begin to try to understand such narrative accounts then we are using a hermeneutic method of therapeutic narrative analysis. Narrative will be the story that brings these episodes together. In this way we can use a variety of textual materials: written reports, spoken stories, visual media, recorded materials and musical material in the telling of the story. The research part is the analysis of those narrative materials that bring forth new therapeutic understandings; hence, Therapeutic Narrative Analysis.

As we saw in Chapter 4, when we move from the phenomena of the music therapy experience itself through a series of abstractions, those abstractions are removed from that very initial experience.

## **Therapeutic narrative analysis as process**

As an introduction we offer an overview of phases in the research process. These phases will be elaborated later in the chapter.

### *Phase 1: Identify the narrative*

Gather the material together that will form the narrative. This may be a case study, or it may be a series of case studies. It is the story that you wish to tell. In this book we use two case studies based on two melodic improvisations.

### *Phase 2: Define the ecology of ideas and settings*

Explicate the theoretical ideas present in the literature or from your own standpoint. This is the initial locating of the research context in the wider perspective of current knowledge (context 1). While this may seem like a literature review, the intention is not to give an exhaustive account of all possible papers but to locate the study in an ecology of ideas. It may well be that this enfolding of the study into literature contexts will occur throughout the study. Indeed, when we study, we read and collect new material. Similarly, at the end of a study we are challenged either to put our new findings into a new theoretical construct or place it within an established landscape of thought. We have seen this in the first chapters with regard to melody.

Define the setting in which the narrative occurred. This will include details of the place of practice, with demographic details of those involved; it may include historical details (context 2). We saw this in the last chapter, locating the studies in a hospital context. Contexts 1 and 2 are ecological explanations; the subjects of the researching are placed in an ecology of ideas, times and situations (Aldridge 1985; Bateson 1972, 1978, 1991).

### *Phase 3: Identify the episodes and generate categories*

Identify episodes that are crucial for analysis. This is inevitably a subjective process but this process can be validated by giving the material to colleagues to see if they identify the same episodes. When we collect a wealth of case study material, we often cannot analyse it all. There has to be a discriminatory choice of what we will focus upon.

Generate a set of constructs from that episodic material and identify categories for analysis. We will see this in the next chapter, where episodes are identified.

### *Phase 4: Submit the episodes to analysis*

The episodes are then analysed according to their content using the guiding framework of the constructs.

### *Phase 5: Explicate the research narrative*

This is the completed narrative based on the understandings gleaned from the analysis of the episodes. We weave together the categories of understandings from the previous phases: this is the process of synthesis following analysis.

## Getting at knowledge

One of the tasks of the researcher in a qualitative approach is to make tacit knowledge, as a therapist, available as propositional knowledge. The purpose of some research is indeed to find out what we know. A conversational paradigm is used here to draw out how the therapist understands her own work, and elicit the structure of her understandings not immediately apparent in everyday conversation. From this perspective, this work is hermeneutic; that is, it is concerned with the significance of human understandings and their interpretation.

A strength of qualitative research is that it concerns itself with interpretation. It is hermeneutic (Moustakas 1990), and therefore has a resonance with the very processes involved in music therapy as the therapist tries to understand his, or her, patient. It is important to note here that we are working from the premise that therapists invest their practice with an element of deep personal meaning. As the music semiologist Nattiez remarks: 'The musicologist's persona is present behind his or her own discourse' (1990, p.210).

It is also important to emphasize that talking about therapy is several steps removed from the actual activity in which we partake. Dancing, painting, singing, acting, doing therapy are different activities from talking about dancing, talking about singing, talking about painting and talking about doing therapy. As we saw in Chapter 4, there are also different levels of interpretation that include experience, description and interpretation as discourse (see Table 5.1).

For the musicologist Nattiez (1990), it is at the level of discourse where poesis and esthesis take place; that is, conclusions are drawn about the music. At this level, we make interpretations of what is happening in the therapy; what the activities of therapist and patient mean. In the current climate of evidence-based medicine, we are being challenged to demonstrate that changes occur. However, what many of us have asked in our research over the years is not just what changes occur, but what those changes mean to the sufferer and the practitioner. Consider the dying patient suffering from intractable pain as a consequence of advanced cancer who, when asked by her physician after a music therapy session, reports 'I am in Beauty'. This demands interpretation and is significant for the patient, and as it turns out for the well-being of her family and friends. But it would not appear on a questionnaire. The medical outcome was negative, the patient died shortly afterwards. The existential and immediate outcome was positive and requires another form of research evidence.

**Table 5.1** Relationships between Nattiez's analytic situations and music therapy interpretations

Analytical situations after Nattiez	Music therapy interpretations	
	The music therapy session	<b>Level 1</b> The sounds themselves, the experience as itself, the performance as phenomena
I Immanent analysis, neutral ground of the music, the physical corpus being studied, the trace II Inductive poietics III External poietics	The score as a description of musical events  The music therapy index of events Clinical reports from other practitioners, drawings from art therapists	<b>Level 2</b> Revelation and description Descriptions of what happens in the therapeutic situation
IV Inductive esthetics  V External esthetics	Music therapy meanings, interpretations of therapeutic significance  Sampling methods from psychology or expert assessment of chosen episodes as part of a research methodology	<b>Level 3</b> Interpretation and discourse Relationship between the musical or clinical activity and the system of interpretations
VI A complex immanent analysis relating the neutral ground of the music to both the poietic and the esthetic	Therapeutic interpretation from a fixed point but intuitively used in the therapeutic explanation	<b>Level 4</b> Meta discourse, comparing systems of interpretations

### A shared language

At the level of performance, what passes in the therapeutic session exists for itself. However, as therapists working together with patients we do need to talk to each other about what happens and what we do. We also need to talk with our patients about what has happened and understand how they make sense of the therapy. Knowing at which level we are talking will aid our discussion and prevent

confusion. Our contention is that we need to find a basic shared language at level 2 in Table 5.1, which is based upon descriptions of the artistic process, yet not too far removed from the activity of therapy itself. This is the level where personal construals emerge as revelations, where we put a name to what is going on. It is a level of description. By doing so, we can then discern when the therapeutic process is being described at level 3, that of interpretation and inference. At this level we begin to find commonalities between individual discourses and these are the languages of the therapeutic discourses that we are trained in. This is a step forward on the road to establishing the meaning of events in clinical practice. There may indeed be further levels of interpretation. Take, for example, the various schools of psychoanalytic therapy, or the different humanistic approaches; each will have a varying interpretation system that may find some commonality at a meta-level of interpretation.

This is not confined solely to qualitative research; clinical reports, assessment using standardized questionnaires and reference to statistics are formal systems of interpretation.

Nattiez (1990, pp.140–142) gives examples of varying relationships between description of the music and the interpretations of meaning that the description holds for the researcher. These relationships can be translated into the music therapy situation, and the music therapy research approach. In Table 5.1 we see in situations III and V the inclusion of external interpretations of the therapeutic events that will include more than the music itself.

Note that Nattiez, as a musicologist, is willing to include in an analysis more than the musical events themselves. We have a similar situation in music therapy in clinical settings where not only is the music available as a tape recording (situation I) enhanced by a commentary from the therapist (situation II), but there are also clinical reports available from other practitioners (Martinez 1998). What significance those descriptions and interpretations have for practice will then be assumed under situations IV and V, inductive and external esthetics.

We have a similar situation when we talk about music, which really might be better expressed as ‘musics’. There are levels of music preferences. In the English folk music scene there were people who would listen only to unaccompanied songs from the British or Celtic tradition. Guitars were banned and Americanizations were outlawed. There were other groups, however, that refused to accommodate such ‘finger in the ear music’. But these could be included in a general category of British folk music that would also fall under a broader generalization of ‘folk music’, probably now interpreted as ‘world music’ (that is, not celestial, planetary or cosmic musics).

We have our own personal musical listening preferences and performances. These lend us an identity. Anyone looking through our CD collections at home will recognize something personal, and social, about us the authors. Looking at the complete works of Van Morrison, Ry Cooder, Bob Dylan, the Waterboys, Buffalo Springfield and Bruce Springsteen says something about where one of us is coming from in terms of musical taste. The musical scores of piano music from Chopin, Janacek and Granados lend another musical identity. There are also the mutual musics of playing in therapy, or singing with children, our singing with football supporters, or playing in the band. We identify with genres and generations. Pete Townsend's 'My Generation' is our generation, although we didn't die before we got old, we simply listen to old Van Morrison recordings!

At each level of musical description, then, there will be a musical meaning for the interpreter. Eliciting this meaning is a major step in understanding how the researcher interprets the material she has before her.

### **Personal construct theory**

The personal construct theory of George Kelly (Kelly, 1955), and the repertory grid method that is allied to it, were designed specifically to elicit systems of meaning. This approach does not concern itself with identifying a normative pattern, rather it makes explicit idiosyncratic meanings. However, while each set of meanings is personal, and therefore unique, there is built into the theory an awareness that we live in shared cultures and that we can share experiences and meanings with others. The personal construct theory method allows us to make our understandings, our construals, of the world clear to others such that we can identify shared meanings. As Kelly devised this conversational method for teaching situations, counselling and therapy, we can see the potential relevance for the creative arts therapies and for supervision. Indeed, Kelly discusses human beings as having a scientific approach. He proposes that we develop ideas about the world as hypotheses and then test them out in practice. According to the experiences we have, we then revise our hypotheses in the light of what has happened. Our experiences shape, and are shaped by, our construals. Each situation offers the potential for an alternative construction of reality. The personal construct approach allows us to elicit meanings about specific natural settings as we have experienced, or can imagine, them.

The important factor in this method is that it allows the therapist to stay close to his or her practice and use the appropriate language related to that practice. What it offers is a means of validating subjectivity, we see how the therapist, as researcher, is basing his language in experience. Furthermore, it challenges the researcher to



understand that descriptions are not neutral, and to understand the transition from description to interpretation.

Qualitative methods, and particularly those proposed by Lincoln and Guba (Guba and Lincoln 1989; Lincoln and Guba 1985), present themselves as being constructivist. Therefore, there should be a historical link with Kelly's personal construct theory. However, nowhere in any of the major books related to qualitative research cited above do we find any reference to Kelly. It is only in Moustakas (1990) that we find a reference to Kelly in terms of 'immersion' where, during the collection of research data, the researcher as 'subject' is asked what he or she thinks is being done. While some commentators have found Kelly to be rather cognitive in his approach, this may be due to the way in which his ideas are taught. A reading of Kelly himself stresses the application of beliefs about the world in practice, and that the words that are used to identify constructs are *not* the constructs themselves. He argues that we each of us have a personal belief system by which we actively interpret the world. We create and change the world along with our theories. While we may be charged with bringing those beliefs into the realm of words and conscious expression that does not mean that those beliefs are verbal, or necessarily conscious. This is an important point for the music therapist who is often asked to translate his musical experiences and understandings into the realm of verbal expression. Knowing that some slippage occurs between these realms is an important stage in our understanding.

Making clear constructions of the world is important for establishing credibility. We can see how the world is constructed. The therapist can reflect upon her own construction of the world of clinical practice. Such understandings are discovered when we talk to each other, sometimes called the 'conversational paradigm' (Thomas and Harri-Augstein 1985). Each person has his or her own set of personal meanings that can be communicated, but these meanings can be shared with another person. In this way of working, the personal construing of the world is primary in evaluating the world and leans towards the narrative methods of qualitative research. Sharing those meanings with others must be negotiated and is, therefore, a social activity. To establish our credibility and trustworthiness as researchers, then we need to make explicit our understandings of the world in some form or other. The repertory grid approach is one such way of eliciting and presenting such understandings as a formal process or method.

## **The process**

See Table 5.2



## Phase 1

This is where the materials to be studied together are gathered together. Narratives have a structure, there are themes and plots that are played out in scenes and vignettes. This is where we gather together the stuff of our story following the definition of our research question. In the tradition of qualitative research, this may be a stage in the process that is reiterated. We may find as the story unfolds that other scenes need to be included. It is a stage of focusing effort and gathering together the case material to be used. The selection of material may also be influenced by phase 2.

**Table 5.2** The phases of therapeutic narrative analysis

<i>Phase 1: Identify the narrative</i>	Gather the material together that will form the narrative. This may be a case study, or it may be a series of case studies. It is the story that you wish to tell.
<i>Phase 2: Define the ecology of ideas and settings</i>	Explicate the theoretical ideas present in the literature or from your own standpoint. This is the initial locating of the research context in the wider perspective of current knowledge (context 1).  Define the setting in which the narrative occurred. This will include details of the place of practice, the demographic details of those involved and may include historical details (context 2).
<i>Phase 3: Identify the episodes and generate categories</i>	Identify episodes that are crucial for analysis.  Generate a set of constructs from that episodic material and identify categories for analysis.
<i>Phase 4: Submit the episodes to analysis</i>	The episodes are then analysed according to their contents using the guiding framework of the constructs. At this stage it is possible to use a regulative rules-based hypothesis.  It is also possible to submit episodes for categorical confirmation to colleagues.
<i>Phase 5 Explicate the research narrative</i>	Interpretations based on therapeutic traces are synthesized to form a therapeutic narrative.

## Phase 2

In phase 2 we locate our narrative amongst the other stories being told. It is a contextual act where we locate the story in a particular culture of stories. Indeed, we may ask our readers to consider the therapeutic narrative from a particular methodological perspective; as ethnomethodology for example, or as ethnomusicology. Or we may locate that narrative in a theoretical framework like the traditions of psychotherapy and medicine. Others may want to base their stories in concrete data traces

drawing from published literature. This phase is where the content of the study is placed into context.

In considering influential theories, these too may influence the choice of case material. This is a process of theoretical sampling, *not* random sampling. What is being presented here is a retrospective method.

### *Phase 3*

Phase 3 brings us to the stage of identifying the categories inherent in what we have collected together. It is a major step of abstraction. From the material that we have before us we need to select episodes that illustrate our focus of interest. This approach is a conceptual method and depends upon the researcher's ability to identify abstract categories. Abstraction, like interpretation, is a process, often invisible to the researcher, and itself based in a discourse. What we are looking for is recurrent patterns within the material, and then, as Bateson (1978) suggests, the pattern that connects.

We have to identify episodes, and then elicit constructs from those episodes to define the categories for interpretation of the material.

### SELECTION OF EPISODES AS PUNCTUATION

Social scientists have become interested in the way in which we select meaningful patterns of behaviour from the ceaseless stream of events occurring in daily life. This selective structuring has been referred to as 'punctuation' (Bateson 1972). To an outside observer, a series of communications can be viewed as an uninterrupted sequence of interchanges but the participants themselves may introduce episodes of interchange which for them have clear beginnings and endings. Punctuation is seen as organizing behavioural events and is vital to interaction. Culturally we share many conventions of punctuation that serve to organize common and important interactional transactions. We observe this when someone says 'He started the argument' or 'It first began when her work ended'.

The punctuation of events occurs as episodes that we identify. Harre and Secord (1971) define an episode as 'any part of human life, involving one or more people, in which some internal structure can be determined' (p.153). Although imprecise, this definition offers a tool for considering behaviour in that behaviour is located interpersonally and structured (Pearce, Cronen and Conklin 1979). Episodes can be described in ways that represent the process of construing, and that construing can occur at differing levels of meaning (Aldridge 1998).

The punctuation of events into episodes serves the same function as phrasing in musical time. We organize time to make sense in terms of the performed activity.

Thus, if we are looking at videotaped material for examples of interaction with a particular quality, we will identify when that interaction begins and when it ends. We may of course identify differing categories of episode. How we choose to label those episodes is also a matter of construing.

Personally, episodes can be seen as patterns of meanings and behaviours in the minds of individuals. This is a privatized meaning that represents an individual's understanding of the forms of social interaction in which she is participating, or wishes to participate. In a study by Parker (1981), girls deliberately harming themselves describe what they do as similar to being alone and crying or getting drunk. This construing is quite different from a medical perspective that sees the activity as manipulative or as a cry for help.

Relationally, episodes may be construed as common patterns of actions that assume a reciprocal perspective (Aldridge and Dallos 1986; Dallos and Aldridge 1987). Such constrictings are developed through interaction, in the way that people live and play together they coordinate an understanding of what experience means. In therapy, when people are used to playing music together, they begin to construe their musical playing mutually. Note that this mutual construing is musical, it is not necessarily verbal. Our challenge is to convert this musical construing of events into a lexical realm if we want to write about it. The basis of the research material will be audiotape or videotape material.

Culturally, episodes are patterns of meanings and behaviours that are culturally sanctioned and that exist independently of any particular individual meaning. This is perhaps best seen by the 'cry for help' notion of distress. Such constrictings reflect the concept of significant symbols described by Mead (1934) that reflect public shared meanings. We would see such cultural constrictings in the way in which rituals such as marriages and funerals are understood, and ritualized ways of dealing with social events such as greetings, deference and leaving (Geertz 1957). These are seen in music therapy as formalized and ritualized greeting and leaving songs.

#### ELICITING CONSTRUCTS

The first step in this narrative analysis approach is to identify the episodes. The second step is to identify those episodes with names and then to compare those episodes and elicit constructs (see Aldridge 1996a).

An advantage of this way of working, as Kelly himself proposed, is that it elicits verbal labels for constructs that may be preverbal. In terms of a researcher's understanding, and bias, the explications from a musico-therapeutic realm of experience into a verbal realm may be of benefit for practice, supervision and research (Aldridge and Aldridge 1996). The verbalization of musical experiences is one step on the way

to establishing credibility by getting the practitioner to say what he or she means in his or her own words. However, the strength of this approach is that the basis is the practice and that can be a nonverbal musical trace.

The clinician is then asked if this presentation makes any sense to him and any interpretations are noted. It is important to note here that the construals and their interpretations are always made in the words used by the therapist. An advantage of this method is that a phrase can also be used to represent the pole of a construct.

The supervisor or consultant can then also suggest the patterns that she recognizes within the data that make sense for her too. This negotiating of a common sense is a part of the supervisory activity and the ground for establishing validity in a qualitative paradigm. As we will see in Figure 7.2, it is possible to bundle the constructs together to form categories that are then labelled as 'relationship', 'decisiveness' and 'expressivity'.

The computational analysis takes the values of the construct as they are assigned to the elements as if they represented points in space. The dimensions of that space are determined by the number of elements involved (in this case, the elements involved are the selected episodes). The purpose of the analysis is to determine the relationship between the constructs as defined by the elemental space. The computation is looking for patterns in the data and organizes the constructs and elements until patterns are found. This is termed 'cluster analysis', in that clusters of similar data are organized together. What we see is how similar the constructs are when they are plotted in space. Two constructs that appear close together may be being used in the same way. Other constructs may not be equivalent and will affect the whole of the data as a constellation. Indeed, the principal-components analysis of the data presents such a stellar appearance. Here the two principal components of the data are used as axes onto which the constructs are projected. This allows the researcher to gauge the major dimensions on which the experiences of clients are being construed. These two axes appear as horizontal and vertical dotted lines in the figures. We see how balanced/out-of-balance and play-achievement are located along this horizontal play/balance axis, while eye-contact, body movement and dialogue are constructs aligned near to the vertical axis. The task is then to put these constructs together as a concept by asking the therapist what these could mean when considered as a concept.

The focus analysis structures constructs and elements that are closest together in the dimensional space into a linear order. These are then sorted into matching rated scores and mapped according to their similarity (as percentages). Clusters of constructs are then computed by selecting the most similar ratings and presented as a hierarchical tree diagram that shows the linkages between groups of constructs (see

Figure 7.2). In Figure 7.2, similar constructs are arranged together so that we have a visual display, albeit two-dimensional, of how meanings are linked together.

The results of both forms of analyses are then discussed to see what sense emerges from the analysis. At this stage the researcher is encouraged to find labels for construct groupings and these labels themselves represent constructs at a greater level of abstraction. These labels are a step in finding categories for use in analysing case material in qualitative research. There are analogies here with the process of category generation in grounded theory methods and these labels are based on empirical data. For phenomenological research, such categories, once they have been articulated in this way, could be bracketed out of the analysis.

#### *Phase 4*

This is the stage where the episodes are analysed in terms of the constructs and the overarching categories that have been generated.

However, while we may find out how the world is constructed by the therapist, we also need to know the consequences of that meaning. We know the 'what' of meaning. We can understand what this means to the therapist. 'What happens next?' is the appropriate question to ask. Given that we know how a therapist construes a therapeutic event, what he or she does about it is also a vital piece of knowledge. Furthermore, in the process of therapy, we also need to know what the patient will do next and also interpret what that means. Thus we have a chain of understandings and actions from the perspective of the therapist and the patient. Of course, these interactive understandings are dynamic, they change during the play. In some way, this is at the heart of therapy; while being rule-based, what will happen is not fixed, there is always the possibility of something new happening.

Construings and interpretations at different levels can be woven together to formalize a clinical narrative. Such clinical narratives are constructed and based upon rules of interpretation and play.

## The Emergence of a Melody in the Course of an Improvisation: ‘A Walk through Paris’

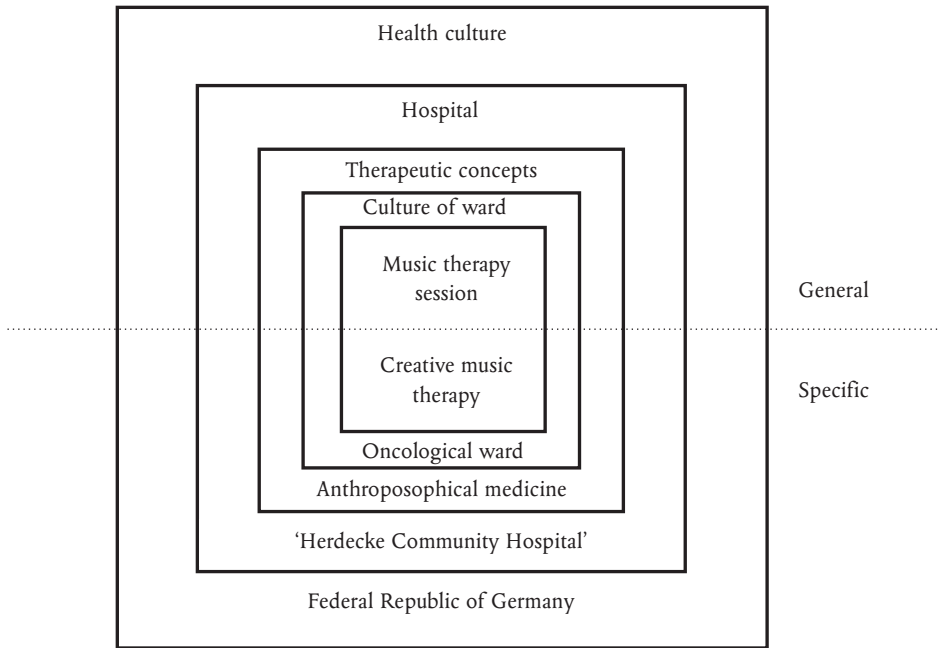
Our first study explores the emergence of a melody with a breast cancer patient. The researcher took her motivation and also the initial idea for this study from this process of experiencing and witnessing the expressive qualities of melodies that emerged during therapy. Both melodies constituted a kind of culmination and at the same time the conclusion of the therapy. Our main thesis is that melodic improvisation may enable patients to bring strong and sometimes contrary emotion into an expressive form that is dynamic and variable and therefore manageable for the patient.

### **The therapy context**

We know that music therapy sessions receive their particular imprint not only from the patient–therapist relationship but also from the respective context that may be cultural in the broadest sense. Figure 6.1 illustrates that music therapy sessions are an integral part of the treatment concept at the Herdecke Community Hospital where these studies took place.

### *The hospital*

In Germany, anthroposophical medicine has been admitted into drug law as part of a pluralistic medicine. This has been applied into the overall concept of the Herdecke Community Hospital, which orientates towards a holistic view of the human being. One of the assumptions of their philosophy is that illnesses and problems arise when



*Figure 6.1 Creative music therapy in the context of hospital culture*

people are estranged from their own creative capacities. This thought can be extended. Illness occurs when we become literally out of time, out of touch, and out of tune with ourselves and others. This lack of harmony, or loss of rhythmical coordination, can be expressed in artistic activities – in movement and dance, in drawing, painting and sculpting, in speech, drama and story-telling, and in the process of creating and playing music.

In the hospital it is common practice that individual therapy concepts are raised for patients in consultation with practitioners, nurses and therapists. A decisive factor of this concept is the patient's involvement in her own healing process, and her inner willingness for processes of change. From this point of view cultural events like concerts, exhibitions, lectures, reading circles and intern events according to the seasons are organized and offered to patients, employees and friends.

According to the overall concept of the hospital, the treatment plan, 'made-to-measure' for each patient, plays an integral part on the wards. It is aligned to arouse and promote the patient's self-healing properties and possibilities for development in physical, psychological, mental and social processes.

On the oncological ward, the therapy-setting is diversified, including eurythmy, art therapy, music therapy, sculptures, and applications like therapeutic baths, compresses, fever-therapy, and mistletoe-therapy.

### *Music therapy concept*

The form of music therapy applied here has its origins in the method initiated by Nordoff and Robbins (1977) for children with mental, emotional and physical handicaps. The focus in music therapy is on the joint improvisation by patient and therapist on various rhythmic–melodic instruments. This form of improvisational music therapy is by no means a generally binding method with strict rules. It has idiosyncratic components and takes the childrens' and therapists' individual qualities into account. In this 'composed' form of music therapy, each therapist has to find and shape her personal method in accordance with her individual musical abilities and those of the patient.

The patient in the first study received music therapy treatment during a rather short postoperative period of three weeks on the ward with a total of six sessions. These took place twice a week and lasted 45 minutes each.

### **The illness in context**

Do not ask for the disease a person has, but for the person who has this disease.  
(Sacks 1995, p.9)

This section will give a short description of the significance of cancer in our society and point out conspicuous features in relevant literature on psychology, sociology and music therapy. This insight will hopefully permit a reader to consider the results of the first study against this background from a more comprehensive and expanded perspective. A short description of the patient's specific situation will follow.

### *Breast cancer*

Among the approximately 200 different types of cancer, breast cancer is the most frequent in women, with still increasing incidence. Nevertheless, survival rates are highest among breast cancer patients.

Literature contains many reflections upon the significance of diagnosed cancer and the role this illness plays in our society. Cancer as a disease of the body that may spread and expand is seen in our society not only as an illness but virtually as a vicious, invincible enemy that may endanger our lives and all our chances of a successful career and personal development. For Susan Sontag (1993), cancer with its still undiscovered causality has the highest potential to serve as a metaphor of what is considered morally wrong in our society. Similarly, Wilkinson thinks it is not by chance that reflections on this illness are often located within a moral context (Wilkinson and Kitzinger 1993).



In our Western civilization where the female breast constitutes part of the cultural code for femininity and sexuality, breast cancer is a particularly profound and possibly traumatizing experience (Wear 1993). The most appalling consequences of this disease are the mutilation or amputation of a body part, the pain involved, the insecure treatment results, the fear of a renewed outbreak of cancer, and the fear of death. This disease thus evokes fundamental fears associated with susceptibility, hopelessness and an unknown future (Wong and Bramwell 1992). During this stage of deepest insecurity, the question of guilt may emerge, and we are tempted to identify those things we fear most and find disgusting and ugly with the disease itself.

### *Coping and psychosocial factors*

Patients suffer from numerous mental, social and emotional stress factors and therefore require coping mechanisms in order to maintain their inner balance. The indicators quoted most frequently are those of depression, anxiety, rage, fatigue, desperation and insecurity. Psychological effects of this life-threatening disease have been analysed intensively from different perspectives in various psycho-oncological studies (Berti, Hoffmann and Möbus 1993; Carter 1993; Carter, Carter and Prosen 1992; Cunningham 1993; Geyer 1993; Hürny *et al.* 1993; Nelson *et al.* 1994; Rawnsley 1994; Shapiro *et al.* 1994; Stanton and Snider 1993; Wong and Bramwell 1992).

Results from these studies point to the beneficial effect of psychosocial interventions that may influence the progression of the disease. Spiegel (1991), in a study with breast cancer patients, explored the effect of psychosocial intervention on his clients' mood and sensation of pain; he found a positive effect on these variables, manifest not only in a reduction of changes of mood and of pain but also in reduced phobia and better coping reactions. Consequently, he sees the advantage of psychosocial intervention in an essentially improved quality of life for his patients. Another significant effect concerns a markedly higher optimism in outlook. This becomes evident in reduced feelings of isolation and hopelessness, but also in an identifiable increase of natural killer cells as an important element of the immune defence system against cancer (Andersen 1992; Eysenck 1994; Levy *et al.* 1992).

In general, the hospitalization period with surgery is described in literature as one of the most difficult phases in the course of the disease (Heim *et al.* 1993; Stanton and Snider 1993). Patients are confronted not only with the risk of surgery and a possible negative prognosis, but also with the loss of the breast, which results in a distorted body image and a loss of self-esteem. An issue frequently addressed in nursing literature is a demand for emotional support for patients during this stressful

period (Carter 1993, 1994; Wong and Bramwell 1992). Results from a Swedish study by Palsson and Norberg (1995) confirmed that emotional encouragement as well as reorganized patient care (e.g. shorter waiting periods between diagnosis and cytological analysis, personal interviews with physician and nurse on diagnoses continuing in the hospitalization period, or contact with a community nurse before and after release from hospital) helped many patients to develop a feeling of security and of being protected.

### **Breast cancer and music therapy**

Due to the extremely stressful nature of a cancer experience, cancer treatment requires a complex treatment scheme reaching beyond mere medical therapies and involving psychological, psychosocial and social aspects as well. Music therapy, with its specific potential to influence emotional stress factors, has gained significance in this context.

In the 'Supportive Care Program of the Pain Service' on the neurology ward at the Sloan-Kettering Cancer Center, New York, music therapy is employed to reduce anxiety, to encourage relaxation, to support other pain control measures and to improve communication between patients and their families (Bailey 1983, 1985, 1986; Coyle 1987). Depression being a frequent occurrence among this patient group, music therapy may well have an influence on this parameter and contribute to improved quality of life.

Heyde and von Langsdorff (1983) underline the usefulness of a therapy programme that is based on simultaneous activity and perception. For them, the discovery of unexpected abilities is a chance to muster new energies. They believe that an emotional experience of success in creative artistic activities may help to reduce individual and highly different psychosocial problems. However, they have not provided evidence to this effect so far. Indications for the positive effect of music therapy and other arts therapies are mostly of a subjective nature. Bailey (1983) discovered a significant improvement in the mood of cancer patients when they listened to live music instead of music recorded on tape. She attributed this to the human element in the therapist being more involved with the music-making.

The receptive use of music plays a significant role in chemotherapy. Here it serves as a means of relaxation and distraction (Kammrath 1989). Many cancer patients are reported to feel a general improvement, and less sickness and vomiting (Kerkvliet 1990). Frank (1985) used music on audio cassettes and 'guided imagery' in combination with pharmacological substances against vomiting in a study and found that 'state anxiety' was clearly reduced, followed by a marked decrease in vomiting. Feelings of sickness, however, were not reduced. The fact that participants

felt improvements was seen as an encouraging sign to use music therapy as a complementary therapy.

### *Music therapy and reduced pain*

The distracting effect of music is also observed in pain control (Foley 1986). In a study by Zimmermann *et al.* (1989), a control group of patients suffering from chronic pain listened to their favourite music from tape in combination with suggestion. The researchers noted relief not only from emotional pain but also from immediate physical pain. This suggests that the use of music therapy has a direct influence on sensory parameters.

### *Music therapy and coping*

The possibility, as mentioned above, of exerting a beneficial influence on emotions with music gains in significance when we consider its usefulness for the coping process. We know from literature that mental and social stress may affect coping activities and consequently may influence the immune system. We might speculate that positive emotions stimulated by creative music therapy can intensify coping activities and thus exert a positive influence on a heightened immune system.

Improvised music therapy involves the patient as an autonomous, active partner in the musical process. It corresponds to the basic concept pursued at the Herdecke Community Hospital where patients are seen as active partners in medical care and not forced into the role of passive recipients of medical treatment. This aspect of patients influencing their own fate is important for both the course of music therapy and within the ethos of the ward and hospital itself. Patients have the opportunity to influence their type of music-making, to give it a new direction and thus to assume responsibility for what they do. The performance of a musical process with the changes involved, comparable to those in social and family life, may thus become a joint effort in music as well. There is no implication here that patients are blamed for falling ill or not regaining health, simply emphasizing that becoming healthy is an activity in which we can take part, just as pursuing a healthy lifestyle will help us to face health challenges like the influenza virus but does not ignore that 'flu happens.

In this context we would like to refer to the perspective of a phenomenological comparison between the organization of music and the organization of the self (Aldridge 1989): a correlation between musical form and biological form. In using a musical metaphor, we offer a perspective that suggests human identity is like a piece of symphonic music being continuously composed in the moment. This is in contrast to a mechanistic perspective of the human existence that fixes on the

physical body alone and sees it as something that has to be repaired. The emphasis here is on bringing activity into form – that is, the dynamic process of forming.

The application of the musical metaphor to a human individual enables him or her to ‘listen’ to it as a holistic organisation in a dynamic way, not only within his or her own musical performance but also in relation to the therapist. Through the form of musical dialogue patients are able, with the help of a rhythmic motif, to achieve a mutual exchange of emotions and to regulate these in their musical play. Such considerations are also supported by our argument that prosodic musical components are the fundamental elements of communication (Aldridge 1996c) and rhythm is a main factor in communication and of fundamental significance for the way in which we enter into relationships with ourselves and with others. Since the musical time structure within which the musical expression of rhythmic–melodic motifs takes place is not static, it is possible, with the help of this form, to influence a flexible reaction on the part of the patients that is also coherent.

### *The patient’s clinical situation*

The patient in this first study opted for the Herdecke Community Hospital for surgery and treatment in view of their holistic approach and the wide range of therapies on offer. At the time of her surgery, she was 33 years old, married and had a 5-year-old son. The reason for the surgery was a large invasive ductal carcinoma in the left breast (grade 2). In addition, four axillary lymph nodes were removed. She received radiotherapy, mistletoe therapy, pyretotherapy,<sup>1</sup> as well as eurhythmics<sup>2</sup> and music therapy.

### **The melody ‘A Walk through Paris’**

The melody presented in this section was created in the patient’s sixth, and final, session and constitutes the main element of that session, where the patient expresses a wish to play the metallophone. The therapist arranges the metallophone with the scale of C-minor and accompanies her on the piano. This melody is the starting-point of the analytical process, since it is used as the basis for the research; the emergence of this melody prompted the question of whether the melody developed between the first and last sessions of therapy. The melody as it appears here is given

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1 Therapy by raising the body temperature through artificially inducing fever.

2 Eurythmics is harmonious bodily movement, aiming to harmonize mind and body through a system of gymnastics correlated with music.

the title 'A Walk through Paris' as this is what the patient says of the improvisation: *It was like a walk through the sunny streets of Paris.*

We present the most important excerpts from the melodic improvisation, which are the onset with the subsequent development, and two excerpts from the later part of the melodic improvisation. We have marked the melodic phrases in the form of sections with capitals. The sections of the first and longer excerpt have the capitals A to D, the two following sections are marked with E and F and these derive from a later part of the session.

### *Example A: bars 1–8*

The example begins on an upbeat (see Figure 6.2). A rhythmic cell is recognizable. You may see it like the shoot of a plant that in itself has the possibility to develop. It is known that the rhythms are ordered like the ancient system of the verse form, the metrical foot. In the ancient world, the patient's chosen rhythm would be described as an iambic foot. This rhythmical cell is meaningful because it holds the patient within her active playing, gives her a grip on herself, and offers her enough stability to discover the melodic component, and, at the same time, it is a moving impulse leading her into the tonal space of the C-minor scale, which also leads into the harmonic field of C-minor.

From our experience it is a sense of rhythm that allows a sense of melody. As the patient has chosen the form of a metrical foot, it may be seen like a 'way of walking' that is leading her through the improvisation and setting the tone for the rest of the improvisation.

### *Example B: bars 9–20*

Here we no longer see an orientation to the given C-minor tones (see Figure 6.2). The patient is consciously listening, which is apparent in her delicate touch. She is perceiving the tonal space harmonically. She accentuates some central tones: the tonic keynote and the fifth. Her harmonic experience is strengthened by playing in a homophonic way. The patient has chosen orientated fixed notes within the tonal space: she starts from these tones by repeating them and goes back to them. When the piano part, which was in the background, comes into the foreground with a melody, she plays a harmonic middle part. In the last bar the patient comes in with an upbeat melodic figure. This leads to example C.

## Example A

Adagio

Patient

Therapist

P.

Th.

1 2 3 4 5 6 7 8 9

*p*

*p*

## Example B

Patient

P.

P.

9 10 11 12 13 14 15 16 17 18 19

*p*

*p*

Figure 6.2 Onset of the melody and its further course: examples A and B

### Example C: bars 21–32

The patient herself gives melodic form to her improvised playing (see Figure 6.3). The structure of the pitch is in the foreground. The pitch is formed and at the same time she develops rhythmical variety. Both melodic and rhythmic elements are corresponding with each other; they are building a symbiosis. One note is related to another as indicated by the slurs. We can see in this example the development of formal principles of musical composition: the building of two bar phrases, a melodic structure, a tonal orientation returning to the keynote and an experiential element of music played as form.

*Example D: bars 33–44*

This example shows us the development of formal musical principles (see Figure 6.3):

- the development of a bar motif into two-bar phrases
- the emergence of the melodic structure, of diastemy
- the emergence of tonal unity through a return to harmonically central notes
- the experimental experience of bringing music into form in the immediate and present play.

## Example C

Example C shows four staves of music. The first staff, labeled 'Patient', begins at bar 21 and contains measures 21 through 26. The second staff, labeled 'P.', begins at bar 24 and contains measures 24 through 30, with a 'p' dynamic marking under measure 25. The third staff, labeled 'P.', begins at bar 28 and contains measures 28 through 33. The fourth staff, labeled 'P.', begins at bar 31 and contains measures 31 through 33. The music is written in 4/4 time with a key signature of two flats (B-flat major). The notation includes various note values (quarter, eighth, and half notes) and rests, with some measures spanning across staff boundaries.

## Example D

Example D shows four staves of music. The first staff, labeled 'Patient', begins at bar 33 and contains measures 33 through 34. The second staff, labeled 'P.', begins at bar 35 and contains measures 35 through 40, with a 'p' dynamic marking under measure 38. The third staff, labeled 'P.', begins at bar 39 and contains measures 39 through 44. The fourth staff, labeled 'P.', begins at bar 42 and contains measures 42 through 44. The music is written in 4/4 time with a key signature of two flats (B-flat major). The notation includes various note values (quarter, eighth, and half notes) and rests, with some measures spanning across staff boundaries.

Figure 6.3: Subsequent course of the melody: examples C and D

In this example a more shaped melodic line appears. It starts with an upbeat octave leap, followed by ascending and descending tones, which are formed in two-bar phrases. Consequently, the patient makes the tonic keynote audible.

### *Examples E and F*

In section E she accentuates each start of a bar, which corresponds to her descending scale movement (see Figure 6.4). In section F she varies the scale movement in a horizontal line through a kind of ornamentation of the central harmonic notes. The rhythm consists in absolutely even note values (quavers), which means that it is less significant than the pitch height. The meaning of her play here lies in the shaping of the horizontally moved diastemy.

Example E

Patient

P.

Example F

Patient

P.

P.

Figure 6.4 Subsequent course of melody: examples E and F

### *Analysis*

If we analyse the movement in detail we discover typical motif formations, starting with the original rhythmic cell.

In section C (Figure 6.3) she sequences this motif in an upward direction. In section D she underlines the motif more strongly through repetition. We recognize



the correspondence of her melody parts which often comprise four bars. The harmonic structure, offered by the therapist, assumes the tectonic function above which the patient's melodic inspiration evolves freely.

Looking at the melody-movement of the patient's playing in more detail, there are typical forms of motifs that arise out of the first exposed rhythmic cell (see example A). In measures 28–29 she is building sequences of a motif in an upward movement. In measures 40–42 she is giving the motif more importance by repeating it. It is possible to recognize a corresponding melodic construction that often encircles four bars. The harmonic frame, offered by the therapist, takes on the aesthetic musical foundation over which the patient's melodic improvisation can develop freely.

### **The significance of melody**

It is here that we can ask ourselves what it may mean for the patient to express herself melodically. One hint was given by the patient herself when she talked after the improvisation about her feelings and experiences while she was playing. She was accompanied by warm, deep feelings, and her comment on this experience was that 'I had a wonderful walk through the sunny streets of Paris.'

Reflecting on her comments, we discern a positive emotional quality that gives rise to the dimension of hope. This might point out to positive feelings about the future. If we take a closer look, we can refer to the way in which she began her improvisation (example A), with the classical form of an iambic foot as a chosen 'way of walking'. The 'walking' led her, step by step, through the improvisation, and set the tone for the following melodic development. This 'foot' is not static, it implies an intention to walk and which we call here an 'initiation-motif'. At the same time this initiation-motif functions as a mutual pattern of interaction between patient and therapist.

As for the nuances of the patient's emotional expressivity, we see them in the way she combines the elements of rhythm, tension of tone, tone colour, harmony, articulation, phrase and form, and the way that she is able to feel and express herself aesthetically through these elements. This musical expressivity, the gradual development of flowing melodic movement, and the continuing creation of newly arising sequences of tones indicate that the patient, in experiencing the musical elements, develops a flexibility that is supported and held by the harmonic structure offered by the therapist.

The harmonic structure with its strong expressiveness of tension and relaxation contributes to a deeper melodic experience. As the harmonic framework is taken over increasingly and maintained by the therapist, we can propose this as a

'prototype' of tonal confirmation that supports and holds the patient's melodic playing. It may be that the given C-minor harmonic scale, with the causing tension of intrinsic semitones and the augmented second between the sixth and seventh tone, is a trigger for the freely unfolding melodic playing. The inherent tone tension of the scale could have given rise to the kinetic energy and vitality that is shown in her playing. Each tone is placed in a certain balance of strength and tension to the other, and that is articulated and played with a different touch. The patient is giving each tone a functional meaning for the overall melodic course (examples D, E and F). Because of this lively character in the patient's playing, it is not possible to eliminate the emotional quality of her playing from the musical material created by her. It is this fusion of expressivity and musical material that rises above the transient and incidental occurrence of tone sequences. What, in the moment of creation, seems to be incidental becomes for the patient meaningful.

The experience of an unfolding melody is an experience of wholeness, a gestalt, a creation that possesses more features than the sum of its single elements alone would make up (Blume 1989a). The qualities of the melodic gestalt can be proved in this example. They are demonstrated by the concreteness of its form, the synthesis of its single elements as they were listed in the examples, and its possibility for transposition into other registers. We can also think of the wholeness of the patient's experience in walking through the sunny streets of a beautiful town, like Paris, as a pleasurable activity within a magnificent surrounding, full of atmospheric radiation. This experience can also be an aesthetic one that activates and satisfies all our senses. We could say, all our senses are in harmony. And this is what the patient has experienced, the possibility of creating a harmony within herself. This could be a valuable issue for establishing security within herself that would help her to find her path in the time to come.

As we know from the approach of a phenomenological understanding it is possible to experience phenomena as unified wholes (Aldridge 1996b). The notion of being, which looks towards 'being in the world' as a unified experience, can be applied to the patient's experience and extended to 'being in the music'. Within this musical walk the patient could have gained a holistic experience of being in the world. She was able to create this holistic world-experience for herself. It is musically reflected in her intention of creating harmony and relating to basic elements like the basic tone or the fundamental pulse. Harmony in its overriding importance of correspondence, inner unity, well-fitting proportions and melodious sound was musically created by and within herself. It might be possible to think that the patient was able to tune herself with her difficult situation. This leads us to its therapeutic aspect.

In terms of therapeutic value, the melodic improvisation indicates that the patient has found a form with which she can express herself. This can be seen in her ability to combine and balance the elements of rhythm, pitch, tension of tones, harmony, phrasing and form; her ability to express herself freely through these elements; and her relationship to harmony as shown by her orientation to the basic tone. Developing a melodic theme supports her need for expression, providing possibilities to feel and create in her own unique way. She experiences her own creative energy as performed in a time structure that is orientated to her needs. Within the context of the therapeutic relationship she has the possibility to experience herself in a spontaneous and authentic way. Looking at the relation to harmony in the patient's playing, especially to the basic tone, we may presume that the patient has discovered a way of expression that, on one hand, centres on herself and, on the other hand, offers her a reorientation toward herself. Our proposition is that she is encouraged to establish a new identity that is aesthetic and this provides a new orientation in her life. The value of the basic tone that is frequently picked up by the patient is that it anchors this new identity and provides a basis for a new orientation.

# The Process of Listening Analysis

In this part of the book we describe the comprehensive process of listening analysis that we call therapeutic narrative analysis. Listening to therapy sessions is cyclical; we focus on melodic motifs, the inductive, that determines the musical aspects related to the melody, the deductive, and the deductive again takes us back to the level of the inductive. To structure our listening we use an *index*.

For a first overview and general impression of the therapy course, all five therapy sessions of the first study are listened to in one sitting, and a first index for all sessions is set up during this process (see Table 7.1).

**Table 7.1** Steps in the cycle of listening

---

Step 1	Listen to all sessions Set up a four column index of sessions 1–5
Step 2	Short list of relevant music therapy sessions where something appears to happen, sessions 2–4
Step 3	Selection of episodes from those sessions: Episodes 1–16 from sessions 2–4

---

From the first cycle of listening emerges a second one in which significant sessions are selected with important data material on musical–melodious elements, with a resulting concentration on particular episodes. At this stage we are beginning to separate out from the complete musical data that which is interesting and having something to do with the generation of melody. At this stage all we know from our listening is that something has happened.

A further listening phase, step 3 (see Table 7.1), on the basis of these selected sessions, leads to the further selection of certain episodes from the sessions as

material for analysis and interpretation. In this part of the study, we focus on episodes that emerge as elements from the music therapy sessions. Individual sections are selected from the cycle that illustrate the interaction between patient and therapist where something significant has happened for the generation of the melody. This selection of what has happened and is of significance in time is called an 'episode'. These are the moments selected for analysis, and form the basis for the generation of constructs. The analytical cycle of listening in the first study yielded 16 episodes.

We use George Kelly's Personal Construct Theory and the 'repertory grid method' to generate the musical parameters from listening to, and comparing, the selected episodes. This procedure starts with the generation of constructs from listening to the 16 selected episodes and comparing them. This listening again serves as a starting-point to form categories on a more abstract level (Kelly 1955).

### Collecting data: selecting episodes

Kelly's method of comparison helped to entice our ideas and understandings of melody, particularly that which characterizes what is melodious. This analytical part focuses on episodes and their selection for the following reasons:

- The entire therapy course contains so much material that it cannot be evaluated appropriately and in part is of no relevance for my research interest.
- Concentrating on episodes singles out the significant moments in therapy (many therapists encounter such moments in the course of their work and use different terms to describe them, like 'critical moments' (Dorit Amir; 1st International Symposium for Qualitative Research, Düsseldorf, 1994), 'pivotal moments' (Denise Grocke; Research Conference, Melbourne, 1995) or 'arena of change' (Carolyn Kenny; 1st International Symposium for Qualitative Research, Düsseldorf, 1994).

Looking at the roots of the term 'episode', we find the word *epeisodion* (Greek), which means 'additional', 'being added from outside' (Pfeifer 1997, p.291). In ancient Greek tragedies this is the name of the dialogue parts in between the chorus parts. The basic element of 'ep-eis-odion' is *bodos* = way, walk, walking. An episode is any section in human life that involves one or more persons and which may have an inner structure (Aldridge 1996a).

Despite the inherent imprecision, the term is often used to describe human behaviour, localized in and structured by the interpersonal relationship. A description and analysis of episodes may occur on different levels, cultural, personal or family (Aldridge and Aldridge 2002).

On a cultural level, episodes appear as sanctioned patterns of behaviour and meaning, existing independently from a particular individual opinion. At this cultural level, analyses reflect the concept of significant symbols and publicly shared opinions as described by Mead and Duncan (Duncan 1968; Mead 1934). Culturally significant episodes of this kind are rituals like weddings, funerals and ritualized forms of handling social encounters, forms of saying hello and good-bye, and forms of expressing respect.

On a personal level, episodes may be seen as patterns of meaning and behaviour exhibited by individuals. In this case, we have a private opinion representing an individual's understanding of forms and social interactions in which this person is – or wants to be – involved.

At a family level, episodes are seen as general activity patterns which assume a reciprocal perspective (Procter 1981). These family-specific understandings have developed in numerous interactions over longer periods. People coordinate their understandings of the meaning of the world in the way they live together (Aldridge and Aldridge 2002).

**Table 7.2** Sessions, improvisations within sessions and the selected episodes for analysis 1–16

2. Session	1. Improvisation	Episodes 1 – 6
	Pt. 2 Korea drums (hands)	(1) start: rhythmic context
	Th.: piano	(2) subsequently: dialogue
		(3) subsequently: C minor 6/8 beat
		subsequently: inner opening
		(5) subsequently: vocal participation
		end: vocal-instrumental
		final turn
	<b>2. Improvisation</b>	<b>Episodes 7 – 10</b>
	Pt: Metallophone, pentatonic scale	(7) start: melodious context
	c <sup>1</sup> -c <sup>2</sup> , (1 stick)	(8) subsequently: vocal lead
	Th.: chimes c <sup>2</sup> -c <sup>4</sup>	(9) subsequently: phrasing
		(10) subsequently: transformation
	<b>3. Improvisation</b>	<b>Episode 11</b>
	Pt: Metallophone, pentatonic scale	(11) middle part and end: innovatory
	c <sup>1</sup> -a <sup>2</sup> , (2 sticks)	in melody, impulse for final turn
	Th.: piano	

Table 7.2 *continued*

<b>4th Session</b>	<b>2. Improvisation</b>	<b>Episode 12</b>
	Pt: Bongos (hands)	(12) end: adjustment
	Th.: piano	
	<b>3. Improvisation</b>	<b>Episodes 13 – 15</b>
	Pt: Bongos (hands)	start: gradually denser play
	Th.: piano	(14) subsequently: strong expression maintained
		(15) end: final tremolo
	<b>5. Improvisation</b>	<b>Episode 16</b>
	Pt: big drum, small drum, (2 sticks)	(16) start and subsequently:
	Th.: piano	developing form of beat, appropriate use of all instruments

In using episodes for the data material in both studies, we wish to underline that the selected sections are perceived as temporal moments in the therapy course, when patient and therapist pass through something. They are sections where the ‘additional’ is seen as a new experience that may be evoked by ‘something’, such as a new form of expression, action or dialogue. We assume that episodes have an inner structure resulting not only from the intrapersonal, but rather from the interpersonal relation between patient and therapist. The episodes thus contain fundamental data of considerable significance for the research question in that they are dyadic patterns of interaction whose significance must be assessed. Consequently, not the entire therapy sessions are essential, but selected episodes as structured interactions in time.

As we explained before, the first study comprises a total of 16 episodes from two sessions, illustrated in Table 7.2.

### **Validation of episodes with the personal construct theory**

This section describes how the 16 episodes selected from the cycle of listening are analysed with the help of the repertory grid analysis (see Figure 7.1). One way of graphically presenting this material is as a *focus grid* where the results of comparing the different episodes are presented as a grid and the episodes clustered together for similarity (for a detailed discussion of this methodology, see Aldridge 1996a).

### Generation of constructs

In the listening cycle analysis, 16 episodes have been selected from the second and fourth sessions. These episodes are then compared for their similarities and their differences. These comparisons are the comparative poles of the constructs. Each episode functions as an element in the generation of a *repertory grid*. Three episodes are selected at random and then compared in such a way that two are similar in one respect and the third differs from them in this one respect; this procedure is repeated until no further similarities or dissimilarities can be found. Thirteen personal constructs were elicited from the 16 episodes in the first study (see Table 7.3).

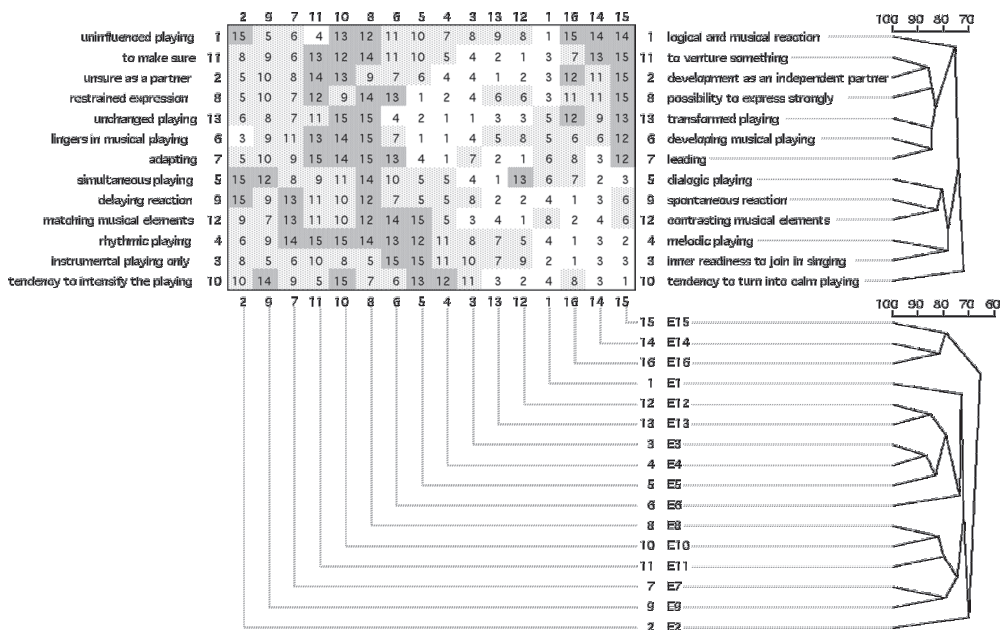


Figure 7.1 The focus grid

### Generation of categories from constructs

From these personal constructs, we can then generate overarching categories that are suggested by the focus grid. If we look at the right-hand side of Figure 7.1, we see how similar constructs are joined together in a tree diagram where similar constructs are linked together according to how the researcher has ranked the constructs. From this mathematical clustering based on the personal rankings that generated the



**Table 7.3** The 13 personal constructs elicited from the 16 episodes

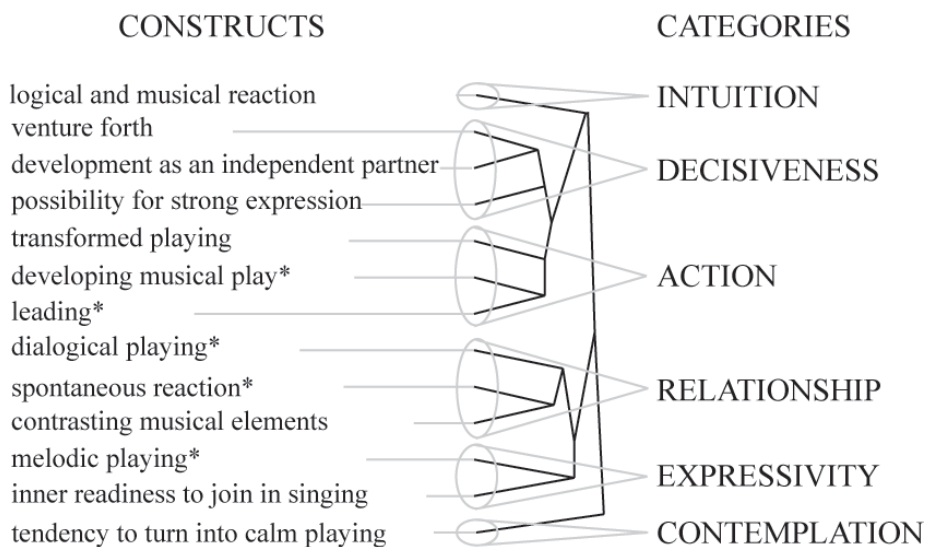
uninfluenced playing	logical and musical reaction
to make sure	to venture something
unsure as a partner	development as an independent partner
restrained expression	possibility to express strongly
unchanged playing	transformed playing
lingers in musical playing	developing musical playing
adapting	leading
simultaneous playing	dialogic playing
delaying reaction	spontaneous reaction
matching musical elements	contrasting musical elements
rhythmic playing	melodic playing
instrumental playing only	inner readiness to join in the singing
tendency to intensify the playing	tendency to turn into calm playing

constructs, we suggest categories for these constructs. The emerging construct categories are illustrated in Figure 7.2. Categorizing is a central feature of qualitative research; what this method does is to make explicit the chain of evidence, the ranking of constructs, on which those categories are based.

### *Categories of episodes*

The grid analysis (bottom right-hand section of Figure 7.1) indicates further patterns resulting from the clustering of the episodes as they are construed. Figure 7.3 shows clusters of two and three, or single outstanding episodes (Episode 2, for example). Eight groups emerge from the cluster pattern and these too are sorted into overarching categories, which are then reduced further to five categories for understanding the episodes. In Figure 7.4, we see how these categories are then applied to the chronological course of the therapy.

The categories of constructs and episodes assume a key function in the subsequent musical analysis. New meanings are generated from personal construals. The 'action' category, for example, is a term of a higher order, comprising the three



\* denotes constructs from the early listening; the other constructs emerged during the process of elicitation

*Figure 7.2 Generation of construct categories from the original constructs*

related constructs ‘leading to transformation’, ‘development of play’ and ‘leading’. We have thus reached a higher level of abstraction that may reveal useful implications of the musical material.

The categories of episodes illustrate the course of time in therapy. From the 16 episodes, eight different periods are seen as significant for the structure and the development of melody.

## Meanings of categories

It is important to clarify the meanings attributed to categories, since this is the only way to explain what the terms mean and how they are interpreted and employed in the context of the first study.

### *Intuition*

The etymological explanation (Pfeifer 1997) of this term is based on the Middle Latin word *intuitio* which means ‘immediate mode of viewing’. Closely related to this explanation is the Latin word *intueri*, meaning to view, look at. The meaning of the term indicates an immediate, comprehensive sensual perception and a direct, not discursive recognition of an occurrence, in contrast to an observation of details. It is an

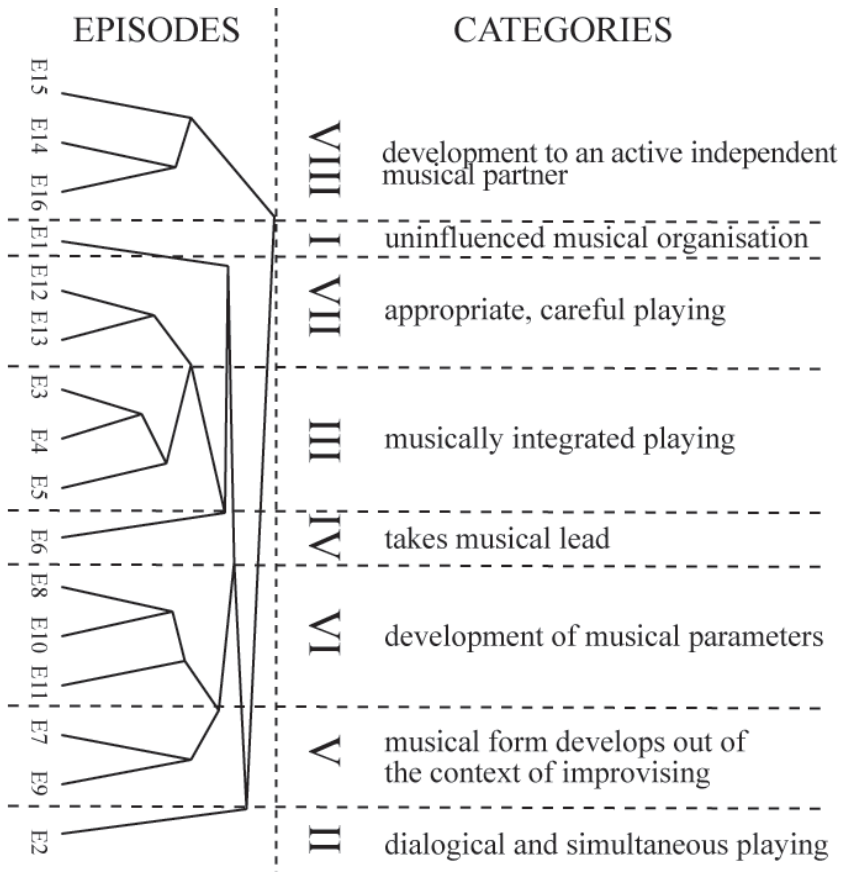


Figure 7.3 Categories of related elements (episodes) from the grid analysis

emotional, instinctive perception of the nature of an object in one act, without reflection characterized by immediacy. This also comprises inspiration and anticipation. In this sense, the significance of this category for this study appears as an intuitive reaction on the part of the patient. The patient perceives and grasps the musical development in its entire context on the basis of her intuition. In adapting to the musical context, she is able to show differentiated musical reactions – hesitant, following or tentatively cooperating.

### *Decisiveness*

This term has its origins in *intsliozan* (Old High German) meaning to unlock, open up; and the word *entsliezen* (Middle High German), meaning to unlock, free, release (Pfeifer 1997). The meaning associated with this category is being in a situation to take a decision: having an inner determination to express oneself, releasing or

C O U R S E  O F  T H E R A P Y	E1	I	uninfluenced musical organisation	COMMUNICATING
	E2	II	dialogical and simultaneous playing	INTEGRATING
	E3 E4 E5	III	musically integrated playing	
	E6	IV	takes musical lead	LEADING
	E7 E9	V	musical form develops out of the context of improvising	FORMING
	E8 E10 E11	VI	development of musical parameters	
	E12 E13	VII	appropriate, careful playing	LEADING
	E15 E14 E16	VIII	development to an active independent musical partner	INDEPENDENCE

Figure 7.4 Reduced categories as they relate to the episodes during the course of the therapy

freeing oneself from something in order to tackle something specific. The patient's coherent identity may be perceived in her music-making insofar as the musical phenomena are in the process of emerging.

### Action

The 'etymological interpretation' (Pfeifer 1997) of the term is related to the Latin *actio* from the sixteenth century, meaning the same thing; closely connected is the Latin *agere, actum*, meaning to drive, act, be active, play a role. Other related terms like the German *Akteur* and *agieren* may provide deeper insights into the meaning of this category. The French *acteur*, Latin *actor, actoris* (gen.) describes not only the acting person but also a person acting on the stage. The verb *agieren* (sixteenth century) has its origin in the Latin *agere* with the basic meaning to drive, drive on, set in motion. Starting from this basic meaning, the verb has developed numerous derivatives and new prefix variations.

In this sense, the patient appears as the ‘acting person’ on an invisible stage when she sets something in motion out of a certain inner state. It is what we refer to as the performative aspect: not ‘I think therefore I am’ but ‘I perform, therefore I am’. Driving something, the music, the patient actively intervenes in the musical process and determines the subsequent musical events. This means:

- being part of the process and being able to act (*alea iacta est* = the die is cast)
- having sufficient determination to be able to act
- being able to react flexibly to external demands (therapist’s interventions)
- being able to react flexibly to one’s own inner demands (internal impulse).

As we saw in Chapters 1 and 2, perception is a holistic strategy that is not limited only to cognitive perception but refers to the deliberate act of experience, the awareness of music and the potential to play. Perception and action are the same wave. Perception is therefore an act of identity and a performance, a Bergsonian virtual action.

### *Relation*

In the ‘etymological interpretation’ (Pfeifer 1997) we find the reference to the verb *ziehen*, in Old High German *ziohan*, Gothic *tiuhan*, Middle High German *ziehen*. The word *ziehen* is related to an Indogerman root *deuk*, meaning draw, or Latin *ducere*, meaning draw, lead. Numerous prefix forms and compounds emerged from this origin. In Middle High German, *beziehen* means to reach or achieve something. The significance of the category ‘relation’ thus appears as a human relationship suggesting an inner connection, which due to the verb forms *ziehen* and *führen* (draw and lead) has an inner element of activity and purpose. In the context of this study this means:

- find one’s position in the musical relationship (patient/therapist)
- the way to enter into musical relationship (intrapersonal and interpersonal)
- perceive and make use of the opportunities of musical ‘entering into relation’ (intrapersonal and interpersonal)
- establish the musical relation in mutual relationship
- the sharing of musical play.

Relationship may be demonstrated by way of the musical principles and parameters. As in all types of communication, we have here an aspect of content and an aspect of relation, the 'what' and the 'how' of understanding (Watzlawick, Beavin and Jackson 1967). While everyday life relations are defined less deliberately and explicitly, they may be immediately heard and revealed in a musical relationship. Watzlawick's suggestion of the definition of a relation may be transferred directly to the musical relationship; this fades into the background the more spontaneous and immediate its expression becomes. On the other hand, problematic relations may be characterized by a mutual struggle for definition, and the contents aspect may become almost totally insignificant in this process. An uninfluenced relationship is revealed in the freedom of musical interpretation that the patient expresses spontaneously and of her own accord. The contents aspect of the relation comes to the fore. The latter is of course dependent on a patient's and therapist's individual skills.

### *Expressivity*

The 'etymological interpretation' (Pfeifer 1997) of the term *Ausdruck* (expression) developed from the Old Germanic verb *drücken*, Old High German *drucchen*. The verb with the original meaning 'to rub, press hard' belonged to the word group dealt with under *drehen*. In Middle High German it was already transferred to mental and emotional pressure without changing its meaning. In the sixteenth century, the verb *ausdrücken* was transferred to linguistic expression, following the example of the Latin *exprimere*, and then to artistic interpretation in general.

The etymological explanation of the term also applies to the music therapy situation. Being able and willing to express oneself presupposes an inner mental and emotional pressure ('to rub, press hard'), which may be transformed in artistic interpretation, release and illustration. The significance of this category for the first study is as follows:

- open up to and be open for expressivity
- allow one's own expressivity, one's personal expression of the particular moment
- the process of finding expression, which may develop and establish itself in the patient's musical play.

### *Contemplation*

This term is derived from the Latin *contemplatio*, meaning mode of viewing, intuition, with the pertinent verb form *contemplari*, meaning view, consider (Pfeifer 1997). The word is related to the Latin *templum* with the original meaning 'demarcated area', an

‘area of bird observation’. The noun becomes a concept in religion and mysticism and describes the immersion into deity and God’s works.

In the context of this study, contemplation means to find an opportunity for inner immersion/absorption and at the same time a return to the inner self in musical expression. This presupposes an inner balance and equilibrium between nearness and distance. The significance of this category is as follows:

- self-reflection and inner collection in musical play
- absorption and immersion in musical play
- inner collection in musical action
- purification and refining in musical play.

## Summary

We now have a basis for analysing the therapy episodes that has been reduced to essential parameters; these are the categories based upon both the constructs and the episodes themselves. The task of the musical analysis will be to see how these categories relate to one another.

**Table 7.4** Construct and episode categories as basic elements for musical analysis

Construct categories	Episode categories
Contemplation	Independence
Expressivity	Forming
Relationship	Leading
Action	Integrating
Decisiveness	Communicating
Intuition	

Our focus has been on categories of constructs and episodes. Figure 7.2 shows the constructs as relevant categories of musical analysis, and Figure 7.4 presents the episodes as relevant categories in the course of the therapy process. The figures gleaned from the grid analysis (Figure 7.1) have made clear that the episodes do not occur in isolation but are connected with each other. The relation between them is determined by the content of constructs. We discover an example of such a pattern of connections in the group of episodes 8, 10 and 11. This cluster of three is an example of the category ‘development of musical parameters’, as we see in Figure

7.3. We then ask ourselves, 'What is the relation between the categories of constructs intuition, action, relation, expressivity and contemplation' in episodes 8, 10 and 11 against the background of the super-ordinate category of FORMING? These connections are the basis for analysis in the next chapter.



# Analysis and Results























This chapter presents our analysis of the episodes from the previous chapter. To enable the reader to follow the details of the analysis, we start with a comprehensive description of the episodes. Additional graphical symbols like arrows and lines serve to illustrate the musical interactions and relations between patient and therapist and initiatives by either or both (see Table 8.1). Circles underline the importance of particularly significant and distinctive musical characteristics. Brackets indicate connected parts like motifs or groups of motifs. In accordance with common practice, small or capital letters respectively are used to differentiate between contrasting or varying motifs, groups of motifs or sections.

## Uninfluenced musical organization (Episode 1)

Episode 1 shows the start of the first improvisation from the second session. The patient plays with both hands on two Korean drums (drums with natural skins) and is accompanied by the therapist on the piano (see Figure 8.1). This episode is determined by the categories intuition and decision. Intuition becomes apparent at the very beginning of this episode. Unaffected by the therapist, the patient starts to play in a moderate pace with a two-measure rhythmic gestalt that is repeated softly (see Figure 8.2).

In the first illustration of this rhythmic gestalt, a slight accent is put on the second part of bar 2. The therapist enters in imitating fashion in bar 3, with a two-measure phrase of a theme in F-minor comprising eight bars, in a rhythmically similar constellation. The end of the two-measure phrase is sharply dotted, so that an upbeat effect results for the following bar, and the musical flow is urged on. A simple accompaniment in fifths to the theme has no significant function and does not appear on the sheet of music.

**Table 8.1** Legend of symbols for the scores used in analysis

	Patient's rhythmic voice on natural skin instruments: Korean drum and bongos (Episodes 1–6, 12–15)
	Patient's rhythmic voice on the big drum (Episode 16)
	Patient's rhythmic voice on the side drum (Episode 16)
	Patient's rhythmic voice on the cymbals (Episode 16)
	Patient's parallel play on the side drum (Episode 16)
	Arrows indicate connecting relations within the music of patient or therapist
	or
	Arrows indicate one-sided inter-musical relations between patient and therapist.
	or
	Arrows indicate inter-musical relations between patient and therapist: originating from both sides
	Emphasis on distinctive musical characteristics
	or
	Identification of certain notes with fixed pitch, unfixed pitch and accent
	or
	Identification of coherent elements, like motifs and groups of motifs
	or
	Identification of coherent elements, like motifs and groups of motifs
	or
	Differentiation between contrasting motifs and groups of motifs
	or
	Differentiation between similar motifs and groups of motifs
	Identification of larger formal sections

Intuition also emerges in bars 8, 10 and 15 (see Figure 8.3). Bars 8 and 10 constitute phrase endings where the patient chooses a consistent mode of play. The final turn in bar 10 shows a stronger semitone tension related to the tonic. In bar 15 we see an animated subdivision between crochet and quavers, which the patient sustains over two bars in rhythmic–melodic variation of the theme. The rhythmic–melodic variation of the theme occurs in a downward movement from  $f^2$  to  $as^1$ .

♩ = 110 Moderato

1

Patient (Korean drum)

Therapist (Piano)

7

P.

Th.

13

P.

Th.

18

P.

Th.

*Figure 8.1 Episode 1*

♩ = 110 Moderato

*mp*

*p*

*Figure 8.2 Intuition*

Bars 11–12 and 19–23 are examples for the category decision (see Figure 8.4). When the theme is repeated, bar 11 and following bars, the patient opts for a variable way of playing when she chooses semiquavers. Again, intuition becomes effective here since the patient anticipates the repetition of the theme. The therapist

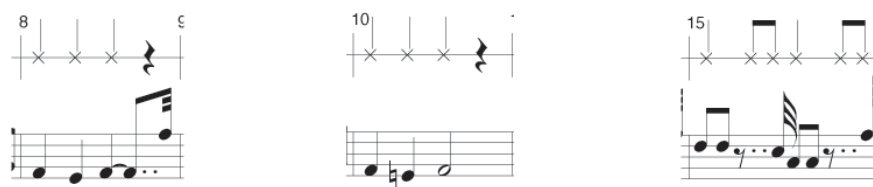


Figure 8.3 Further examples of intuition

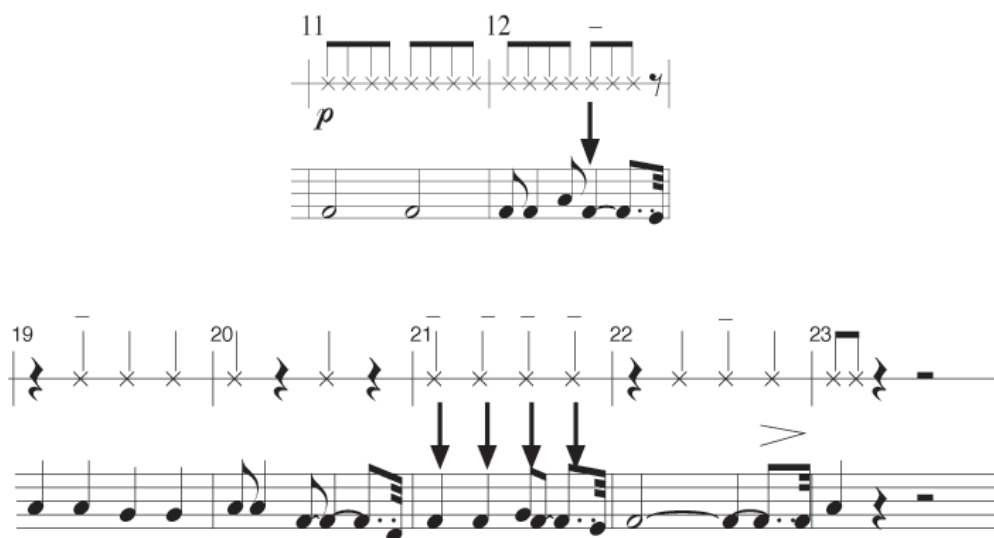


Figure 8.4 Decision

presents the repetition of the theme in a syncopated variant. Bars 15–18 of the varied theme repetition simultaneously lead to a second theme (bars 19–23) which recalls the melody of the spiritual ‘Go down Moses’. This theme retains the syncopations and sharp accentuations as rhythmic characteristics. The patient chooses an accompanying mode here in quarters with stronger accentuation and a decrescendo towards the end of the phrase. This ‘getting weaker’ at the end of a phrase or musical unit also has an element of intuition, as it shows a natural and sensible reaction with regard to making a satisfactory ending.

Episode 1 illustrates that the patient is lively within herself and she is able to introduce this quality into her play. She shows a sensitivity for two-measure motifs and expresses them immediately in her music-making. The therapist reacts accord-

ingly with a clear melodic structure. At the same time she urges the music on with appoggiaturas and portato/staccato articulation. In the therapist's personal notes she writes, 'I try to keep the patient's play going.' Her first impression is that the patient's music is restrained, musically conforming, but also participating, with creative potential. Her creative abilities are implied in rhythm and dynamics, in form and articulation.

### Mode of play: simultaneous and in dialogue form (Episode 2)

Episode 2 follows somewhat later, after Episode 1, and indicates the further course of the first improvisation from the second session. The categories intuition, decision and action are present in this episode. Intuition is apparent in bars 2–5, decision in bars 7–12, and action in bars 13–16 (see Figure 8.5).

The musical score for Episode 2 consists of four systems, each with two staves: Patient (Korean drum) and Therapist (Piano). The key signature is one flat (B-flat) and the time signature is 4/4.

- System 1 (Bars 1-4):** The Patient staff shows a rhythmic pattern of eighth notes with dynamics *p* and *pp*. The Therapist staff shows a melodic line with dynamics *mf*.
- System 2 (Bars 5-8):** The Patient staff includes markings for 'fleeting', 'hasty', and 'subito' with dynamics *pp*. The Therapist staff shows a melodic line with dynamics *p* and *mp*.
- System 3 (Bars 9-12):** The Patient staff includes the marking 'softer, but clearer' with dynamics *p* and *mp*. The Therapist staff shows a melodic line with dynamics *p* and *mp*.
- System 4 (Bars 13-16):** The Patient staff includes markings for 'f', 'ff', 'sfz', and 'tremolo' with dynamics *mp*. The Therapist staff shows a melodic line with dynamics *f* and *mp*.

Figure 8.5 Episode 2

## INTUITION

In bars 2–4, the patient anticipates the ascending triad in F-minor that implies a harmonic development towards the higher fifth (see Figure 8.6). The anticipatory tension produced by this triad is supported by an extension of intervals through octave and appoggiaturas. In the same way, articulation and the clearly stressed quarter rests on the second and fourth beat of the bar create this effect. Due to this musically produced ‘anticipatory tension’, the patient moves to playing semiquavers and concludes it in bar 4 with a crochet on the third beat. A peak has been reached that is emphasized by the following rest. However, the patient herself reduces the intensity with a slight retardation in bars 3–4. This is either an indication of her ambivalence in following, or cautious hesitation. In bar 5, the therapist takes charge and decides how to proceed. A rapidly played triplet in F-major is an invitation for dialogue, and the patient spontaneously responds to this offer. She complements what she hears with the same accentuation and the same rhythmic pattern she used in bar 2; her answer, however, is played in a fugitive manner.

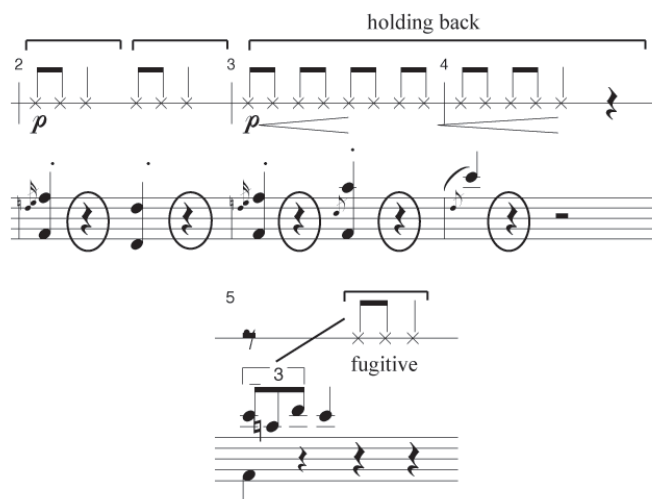


Figure 8.6 Intuition

## DECISION

In bars 7 and 8, the patient varies her response in relation to the minor key introduced by the therapist and decides on subito *pp* and two even crochets (rhythmic augmentation) (see Figure 8.7). Starting with bar 10, the therapist again goes back to the pattern of bar 5. In bar 12 she reduces her response to one crochet. Her play has become more pronounced. The triplet patterns underlined by the therapist (bars 5–8) expose the start of the bars in particular and therefore have a distinctly ‘appeal-

Figure 8.7 Decision

ing' effect that demands complementation. The effect is enhanced by the dissonant timbres of the intervals (ninth) and the diminished triad (d/f/as).

#### ACTION

In bar 13, the therapist takes up the patient's quarter beat from bar 12 and changes over to blocks of powerful chords (see Figure 8.8). The highest notes form a successive melodic course, with leading tone tension and modulating towards C, marked by the dotted line. The blocks of chords alternating with the patient's crochet beats lead to a retardation of the flow. A dynamic development appears in the patient's play, from forte to sforzato and with a final tremolo movement in mezzopiano.

Figure 8.8 Action

The patient's immediate response to the offered dialogue illustrates her spontaneous ability to relate. She is perceptive and shows an intuitive awareness of her own music-making, in a meaningful form and in relation to the therapist's music. Nonetheless, the way she relates to her own music-making is also at times somewhat insecure, distanced, not completely incorporated. This becomes audible in her insecure relation to tempo and a hesitant, ambivalent mode of play. However, she herself produces a change in bar 12 and turns over to action. She reduces her play to one crochet and thus interrupts the metric flow; the movement becomes slower so that there is more room for dynamic expressivity. Here, the patient takes the initiative, supported by the therapist, and pursues the mode emerging in bar 9 with dynamic intensification up to *sforzato*. The patterns of interaction (see Figure 8.9) are controlled, contrasted, developed and varied by both. The interactive play is full of high intensity and attention.

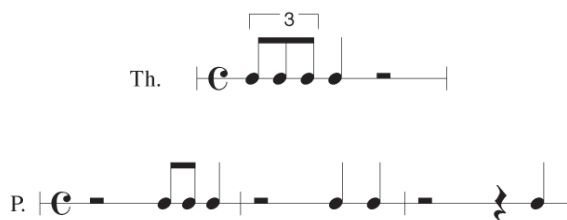


Figure 8.9 *Patterns of interaction*

## **Musically integrative mode of play (Episodes 3, 4 and 5)**

### *Musically integrative mode of play: Episode 3*

Episode 3 is the continuation of the first improvisation from the second session of music therapy (see Figure 8.10). The music has by then been modulated towards C-minor and has assumed the form of a 6/8 measure. The categories relation and decision emerge in this episode. A clear distinction between them is not initially possible; in part they may be applied to the same excerpts. Relation may be detected in bars 1–6, 9, 13 and 18, and decision in bars 5–8 and 12.

#### **RELATION**

Bars 1–4 show that the patient has changed over to a slow theme in C-minor in a swinging 6/8 metre. The episode starts with the first 4-measure phrase of the theme; the phrase ends in a half cadence – the dominant seventh – and thus constitutes an unfinished figure. This first part in four bars corresponds to the antecedent of an 8-measure period. The underlying system with  $2 \rightarrow 2+2 = 4 \rightarrow 4+4 = 8$ ,



Largo  $\text{♩} = 40$

Patient (Korean drum)

Therapist (Piano)

5

P.

Th.

10

P.

Th.

14

P.

Th.

Figure 8.10 Episode 3

with the idea of complementation, analogy and correspondence in mind, also determines the aspects concerning motif and harmony within this episode. The antecedent phrase is repeated several times in this episode so that the structure emerges that we see below:

Bars:	4(1–4)+	4(5–8)+	4(9–12)+	6(13–18)
Sections:	A	A	A	B

The antecedent has the harmony sequence  $t$ ,  $s$  and  $D^7$  appearing in ascending broken chords in accordance with the basic metric accentuation. The melody voice shows a second movement in thirds with ‘a’ as the core motif, which consists in groups of

three quavers, and is repeated. The patient relates to the melody when she takes up the basic rhythmic pattern of the melody which is illustrated in the motif forms 'a' and 'b' (see Figure 8.11). She 'swings' in the 6/8 measure, emphasizing the first and fourth beat (see Figure 8.12).

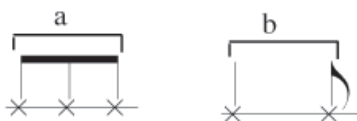


Figure 8.11 Motifs 'a' and 'b'

Largo ♩ = 40

Figure 8.12 Motifs 'a' and 'b' in context and their reflection in musical play

#### RELATION, DECISION

In repeating the theme in bar 5, the patient starts with motif 'b', and continues her mode of play from bars 3–4 (see Figure 8.13). She plays bar 6 simultaneously with the therapist in motif 'a'. The reason might be the upward movement to the fifth. In bar 7, motif 'b' rings out in contrast to 'a' motif. A clear decision in favour of motif 'a' becomes audible in bar 8 where single notes are accentuated. Here she follows the descending melody line that ends in the tension of the half cadence. The antecedent phrase of the theme repeated by the therapist appears without thirds in the repetition; that is, the emerging melody becomes clearer and shows a dynamic progression towards mezzoforte.

With the second repetition of the antecedent phrase in bar 9, motif 'b' is dominant in the patient's play; she starts it with a delayed upbeat quaver. The patient

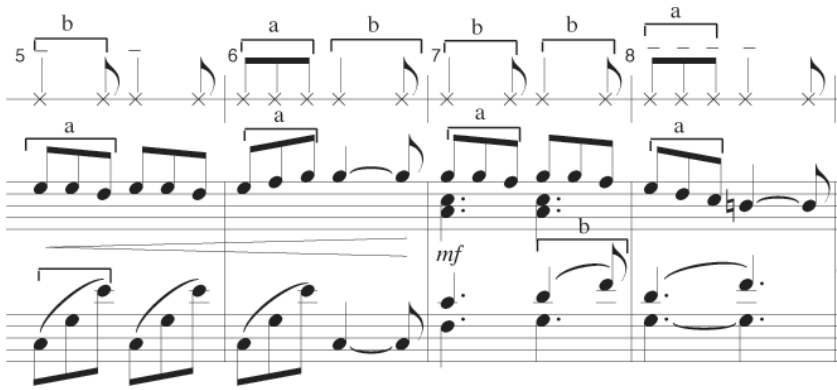


Figure 8.13 *Decision and relation*



Figure 8.14 *Motif 'b' as dominant*

relates here to the therapists's rhythmic accompanying figure. In contrast to the therapist's intensified forte, her play rings out in soft dynamics (see Figure 8.14).

#### DECISION

In the second half of bar 12, at the end of the antecedent phrase, the patient opts for the basic motif 'a' and thereby takes up the therapist's quaver movement (see Figure 8.15). This decision for motif 'a' constitutes the transition to the six-measure consequent phrase (section B).

In assessing the significance of this third episode, the first aspect to mention is the clearly audible interpersonal relationship between patient and therapist. Both share the core elements of the swinging metre. The choice of the largo tempo and C-minor is not only an intuitive decision on the part of the therapist (a feeling for the



Figure 8.15 Patient decides to take up the 'a' motif

patient's inner need for expression), but also reveals a certain characteristic mode of expression. The therapist's personal comment in the index column is: 'An element of trust makes itself felt.' The key C-minor appearing here for the first time and also the 6/8 measure both are important elements in the melody 'A Walk through Paris' of the last session.

Another important point is the patient's involvement in the melodic aspect. She perceives the progress of the melody and the harmonic movement in the bass and forms her own instrumental voice out of both elements. In bars 8 and 12, she almost assumes the dominant role. While she strongly accentuates the melody in bar 8 (the rest in bar 9 might be interpreted as a necessary 'breathing pause' due to the previous accentuation), she uses motif 'a' in bar 12 as a transition to the consequent phrase (section B), which again leads on to the open dominant seventh. The patient consistently employs motif 'b' for the consequent phrase played by the therapist, a peaceful rendition with a tendency towards retardation (bars 17 and 18). Continuing the melodic motif, she becomes absorbed in this peaceful interpretation. Her delay is due to the therapist's rhythmic movement starting in bar 15 and subsequent slowing down. With the renewed half cadence, the end of this episode produces expectation and directs the attention to what comes next in Episode 4.

### *Musically integrative mode of play: Episode 4*

Episode 4 follows immediately upon Episode 3. The most significant category within this episode is relation (see Figure 8.16). It becomes apparent in sections 1–4, 5–8, 9–12 and 13–16. In the last bars of this episode, in bars 12–16, we find the category expressivity.

Figure 8.16 shows the musical score for Episode 4. It is written for Patientin (Koreatr.) and Therapeutin (Klavier). The tempo is marked Andante (♩ = 90). The key signature is C minor (three flats). The score is divided into three systems. The first system starts with a tempo marking and a dynamic of *p*. The second system is marked with a measure number of 6 and the word 'rأسپرن'. The third system is marked with a measure number of 12 and the phrase 'vollerer Klang'. The vocal part (vocal) and piano part (Th.) are shown in C minor.

Figure 8.16 Episode 4

#### RELATION

The therapist introduces a new theme in the same C-minor key. It is set off by its vocal–lyrical component and has a form that may be described as an 8-bar antecedent phrase with a two-measure reference system. This 8-bar antecedent phrase is repeated with a minor rhythmic variant. Altered accentuation produces a 3/4 measure in this part.

The first eight bars are determined by the melodic ascent rising twice (bars 1–2 and 3–4) and one melodic descent to the dominant (bars 5–6 and 7–8). The melodic contour follows a slightly interrupted arch (see Figure 8.17). The twofold melodic ascent consists in the repetition of the motif form ‘a’ (see Figure 8.18).



Figure 8.17 An interrupted melodic arch

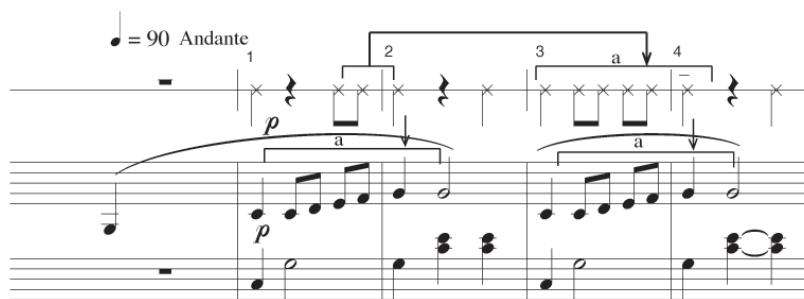


Figure 8.18 *Melodic ascent*

The characteristic fluent quaver movement ascending to the fifth  $g^1$  in step progression after the fourth upbeat produces a minor culminating point. This ascending movement receives its impulse from the accent on the first beat which in bar 2 turns into a contrasting syncope with the repetition of the fifth  $g^1$ . The therapist supports the melody line with her voice. In bars 1–2, the patient relates to the melodic ascent of the motif form ‘a’, as if in reflex action, while in bars 3–4 she clearly takes over the motif group ‘a’. She underlines the melodic culmination,  $g^1$ , with a stress on the first beat (bar 4) and the subsequent rest.

The therapist intones the melodic descent (bars 5–6 + 7–8) with the motif forms ‘b’ and ‘c’ (see Figure 8.19). There is a distinct identity between the two motif forms ‘a’ and ‘b’.

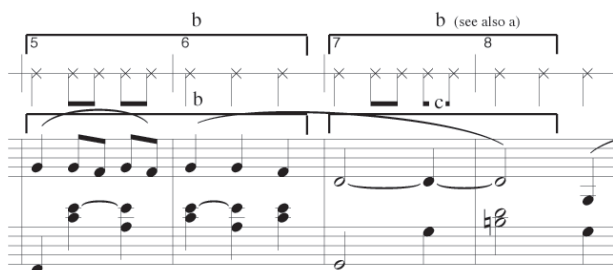


Figure 8.19 *Motifs ‘b’ and ‘c’*

The patient refers to the motif group ‘b’ which she takes over simultaneously with the therapist and carries on over the fading motif form ‘c’.

She reveals the same melodic connection, now more clearly to the motif group ‘a’, in the slightly varied repetition of the theme starting in bar 9. The throat-clearing in bar 10 announces that within herself she is getting ready to sing (see Figure 8.20).

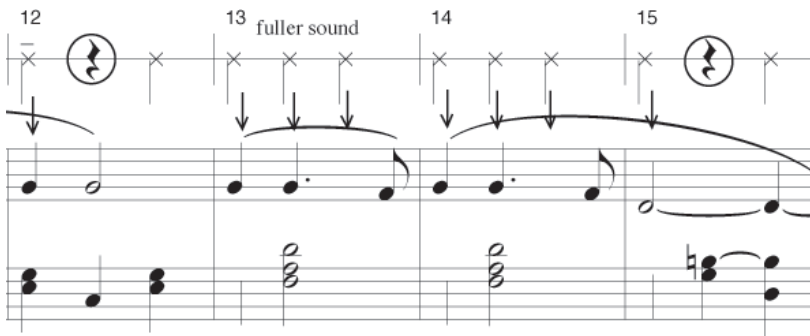


*Figure 8.20 Getting ready to sing*

In bars 10 and 11 her humming becomes audible in some instances. This intrapersonal relation – that the therapist also sees as ‘being touched internally’ – may also be seen in bars 13 and 14 in her more pronounced mode of expression.

#### EXPRESSIVITY

From the perspective of expressivity, the patient starts here to open up internally and to permit an expression of her own to reveal itself. This happens very cautiously and hesitatingly in bars 10–12 with low and almost inaudible humming. It might be interpreted as an inner preparation for an emerging individual expression. The intent to permit a fuller tonal expression becomes audible in bars 12–15 in her mode of play opting for the centre of the drumhead. She leaves out the second beat (quarter rest) in bars 12 and 15 (see also bars 2 and 4) and thus underlines and plays out the bar accent (see Figure 8.21).



*Figure 8.21 Expressivity*

In an analysis of the general significance of this episode for the generation of the melody, we see that the element of trust the therapist already perceived in the third

episode becomes more apparent here. In this context, a peaceful song melody has emerged in a minor key. The therapist's clinical objective was to make the music easier to grasp and more audible for the patient with the help of inner musical references and slightly varied repetition of melodic elements. The invitation to vocalize has strengthened the melodic connection and also provided a link with the expressive element. The connectedness with the melodic element may also be seen in bars 7 and 16 (see Figure 8.22), where the patient carries on the melody form (joint rhythmic form of motif group 'a' and 'b').

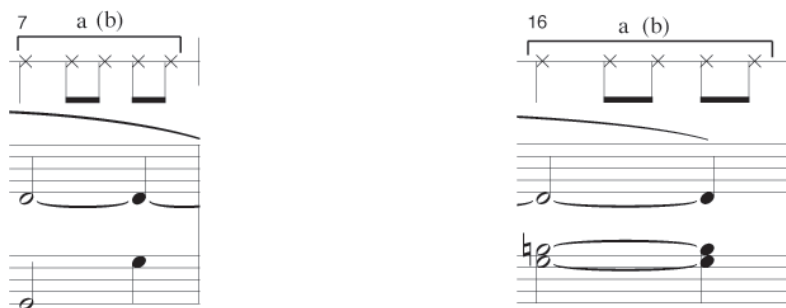


Figure 8.22 Motifs 'a' and 'b'

### *Musically integrative mode of play: Episode 5*

Episode 5 still follows the tonal range of C-minor, with the patient's gradually growing vocal participation (see Figure 8.23). In this episode, the categories relation and expressivity again play a role and carry even more weight. Both categories are represented to equal degrees, whereby expressivity refers more to the patient's singing voice. The patient is able to integrate rhythmic play and vocal interpretation as two different modes of expression and activity. The musical basis of this episode is a two-measure melodic motif (bars 1–2, th. Vocal; Figure 8.24).

The motif is animated in rhythm and syncopated. In the course of episode 5, the appearance of this melodic motif in its rhythmic form remains basically unchanged; the melodic variations result from the harmonic progression and consist in mirror images (bars 3–4, th. vocal) and in sequence formations (bars 11–12, th. vocal).

### RELATIONSHIP

This category reveals itself in the patient's play in many ways. As already mentioned, the patient is able to combine vocal and instrumental aspects. This intra-musical relation appears in bars 2, 4 and 6 in her rhythmic play in the calmly executed basic beat. She chooses quaver subdivisions (bars 3, 7–10, 12–13) on the third beat



Figure 8.23 shows musical notation for Episode 5, featuring three staves: Patient (Vocal), Patient (Korean drum), and Therapist (Vocal). The tempo is marked as 80. The key signature is B-flat major (two flats). The time signature is 3/4.

The notation includes lyrics and musical markings:

- Staff 1 (Patient Vocal):** Lyrics: "Da da da da da da da da". Markings: *pp* (pianissimo).
- Staff 2 (Patient Korean drum):** Marking: *p* (piano).
- Staff 3 (Therapist Vocal):** Lyrics: "da da da da da da da da". Markings: *Piano* (piano).

The notation continues with a second system (measures 5-10) and a third system (measures 11-16). The third system includes the following lyrics and markings:

- Staff 1 (Patient Vocal):** Lyrics: "da da da da da da da da". Markings: *cm in* (C minor), *G Maj7* (G major 7).
- Staff 2 (Patient Korean drum):** Marking: *Piano* (piano).
- Staff 3 (Therapist Vocal):** Lyrics: "da da da da da da da da". Markings: *cm in* (C minor), *Fm in 6* (F minor 6), *cm in* (C minor).

The notation continues with a fourth system (measures 17-22) and a fifth system (measures 23-28). The fifth system includes the following lyrics and markings:

- Staff 1 (Patient Vocal):** Lyrics: "dam da da da da da da da da". Markings: *cm in* (C minor), *G Maj7* (G major 7).
- Staff 2 (Patient Korean drum):** Marking: *Piano* (piano).
- Staff 3 (Therapist Vocal):** Lyrics: "dam ba da da da da da da da da". Markings: *cm in* (C minor).

Figure 8.23 Episode 5

Figure 8.24 shows the melodic motif as a musical basis, consisting of three staves. The key signature is B-flat major (two flats). The time signature is 3/4.

The notation includes the following lyrics and markings:

- Staff 1:** Lyrics: "da da da da da da da da". Marking: *Piano* (piano).
- Staff 2:** Lyrics: "da da da da da da da da". Marking: *Piano* (piano).
- Staff 3:** Lyrics: "da da da da da da da da".

Figure 8.24 The melodic motif as musical basis

exclusively. With a clearly audible reduction of the second and third beat – in part ‘slurred over’ – the upbeat effect to the following, somewhat accented one is more pronounced.

The patient refers in her vocal voice to harmony and the two-measure melodic motif. She anticipates harmonies, mostly chooses the key notes of the harmonies (bars 1–3, 7–8, 13–14) and often the third (bars 4, 6, 9–11) and once the fifth (bar 12). Carrying the key notes of the harmonies over two bars and basically setting them lower compared to the therapist’s melodic voice, she has taken up the function of a second accompanying voice in an ostinato relation to the melodic voice (e.g. bars 1–2; Figure 8.25).



Figure 8.25 *Accompanying voice*

From a musical perspective, the interpersonal relationship between patient and therapist is also achieved through the close interchange and acceptance of the voice-leading and accompanying elements. In bars 7–8, the culminating point of this episode, the patient’s ostinato accompaniment is taken up by the therapist and in this context appears as the melodic culmination above the subdominant in F-minor. The patient supports this culmination in her melodic voice when she relates to the key note  $f^1$ , which she ‘attacks’ from the lower fourth  $c^1$ . In the subsequent bars 9–10, the therapist again takes the melodic lead, while the patient returns to her original ostinato accompanying voice (see Figure 8.26).

#### EXPRESSIVITY

Expressivity is revealed in general in the way the patient expresses herself in voice and rhythm. Her vocal tone is very soft (pp), but distinctly participating on the vocal syllable ‘da’. She has adapted by exhaling as the rhythmic ostinato accompanying

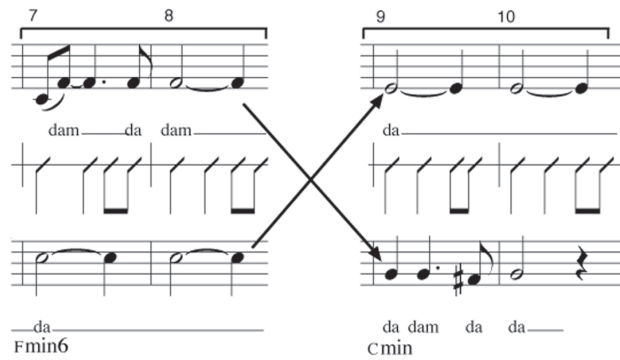


Figure 8.26 *Leading and accompanying*

voice. Starting from the harmonic basic function, she turns over to a kind of polyphonic vocalization (bars 4–6), with a melodic prominence up to the fourth  $f^1$  (bars 7–8). Here she changes her vocal syllable into ‘dam’ (see Figure 8.27).

Her voice continues over the third and fifth of the dominant to the keynote  $c$ , which she reduces vocally and lets fade away on ‘hm’.

The patient’s voice refers strongly to harmony and to the keynotes in particular. The tonal expression of C-minor key is appropriate for her contralto voice and her expressive needs. Although her voice is very cautious, and soft and generally in the background, she shows musical security and finds her way along the basic harmonies of C-minor. This harmonic security is her bridge to the melody. She has to experience herself ‘harmonically’ before she is able to change over to melodic initiatives.

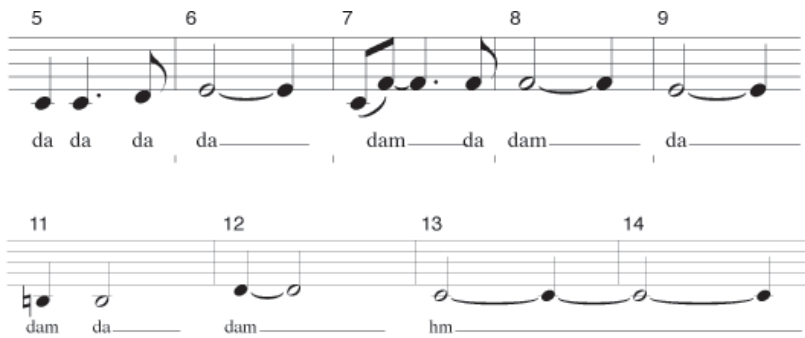


Figure 8.27 *Expressivity and musical security*

Another significant fact is that the patient is able to act on the vocal as well as on the rhythmic–instrumental level. Interior (vocal) and exterior (rhythmic) are combined and relate to the musical context.

### Taking the musical lead (Episode 6)

Episode 6 constitutes the end of the first improvisation from the second session of therapy (see Figure 8.28). The musical material of Episode 6 develops from the preceding Episodes 4 and 5. In the foreground is the melodic motif with its unchanging characteristic rhythm, a dotted note on the second beat (see Figure 8.29).

The musical score for Episode 6 is presented in three systems, each with three staves: Patient (Vocal), Patient (Korean drum), and Therapist (Vocal). The key signature is B-flat major (two flats).

**System 1 (Measures 1-4):** Marked with a tempo of 120 beats per minute (♩ = 120) and the tempo marking 'Allegro'. The Patient (Vocal) part begins with a melodic motif: a dotted quarter note on G4, followed by eighth notes on A4, Bb4, and C5. The Patient (Korean drum) part plays a rhythmic pattern of eighth notes. The Therapist (Vocal) part enters in measure 2 with a melodic motif: a dotted quarter note on G3, followed by eighth notes on A3, Bb3, and C4. The lyrics for the Patient (Vocal) part are 'jam ba da jam ba da jam ba da da'. The lyrics for the Therapist (Vocal) part are 'jam ba da jam ba da da'. The Patient (Korean drum) part has a 'rit.' (ritardando) marking in measure 4.

**System 2 (Measures 5-8):** Marked with a tempo of 70 beats per minute (♩ = 70) and the tempo marking 'Adagio'. The Patient (Vocal) part continues the melodic motif. The Patient (Korean drum) part continues the rhythmic pattern. The Therapist (Vocal) part continues the melodic motif. The lyrics for the Patient (Vocal) part are 'dam ba da dam ba da da'. The lyrics for the Therapist (Vocal) part are 'dam ba da dam ba da da'. The Patient (Korean drum) part has a 'rit.' (ritardando) marking in measure 8.

**System 3 (Measures 9-12):** The Patient (Vocal) part continues the melodic motif. The Patient (Korean drum) part continues the rhythmic pattern. The Therapist (Vocal) part continues the melodic motif. The lyrics for the Patient (Vocal) part are 'da da da da da da'. The lyrics for the Therapist (Vocal) part are 'da da da da da da'. The Patient (Korean drum) part has a 'rit.' (ritardando) marking in measure 10.

Figure 8.28 Episode 6



Figure 8.29 *The characteristic rhythm of the developing melodic motif*

The emergence and progress of this melodic motif can be followed through Episodes 4 to 6. In Episode 4 its final rhythmic shape appears, in Episode 5 it turns up in different variations and modifications, and in Episode 6 it is intensified through a sequence of its harmonic legato within a four-measure phrase.

In addition to the categories relation and expressivity, the action category comes into play here. All three categories are musically interconnected and influence each other simultaneously (see Figure 8.30).



Figure 8.30 *Action*

In bars 1–4 the patient ventures out with her voice, which is now more clearly audible (mf). She is stimulated by the therapist, who shortly before has intensified the tempo (allegro), the volume (ff) and also vocal expression. She joins in with the change in the vocal syllables, which in connection with the rhythmic syncopation underlines the animated character of these bars.

She can now extend a single breath over four bars following the melodic phrase. In the patient's rhythmic play, action becomes also apparent in the denser rhythmic movement (see Figure 8.31). In bar 4, she uses this quaver movement to introduce a ritardando which she takes over into a new and slower adagio tempo (see Figure 8.32).



Figure 8.31 *Denser rhythmic movement*



Figure 8.32 *Ritardando brings change in tempo*

The patient takes an active part in the final turn as well. In bar 10 she initiates another ritardando with her rhythmic play, with a subsequent softly fading tremolo movement, and marks the end of this episode – which also forms the end of the first improvisation.

#### RELATION

In the adagio section from bar 5 onwards, the patient frees herself from the lower accompanying voice and changes over to the melody voice, ringing out in unison together with the therapist (see Figure 8.33). This close melodic relationship extends to bar 13, the end of the episode. The melody movement mostly follows a step progression and therefore is easy to vocalize.

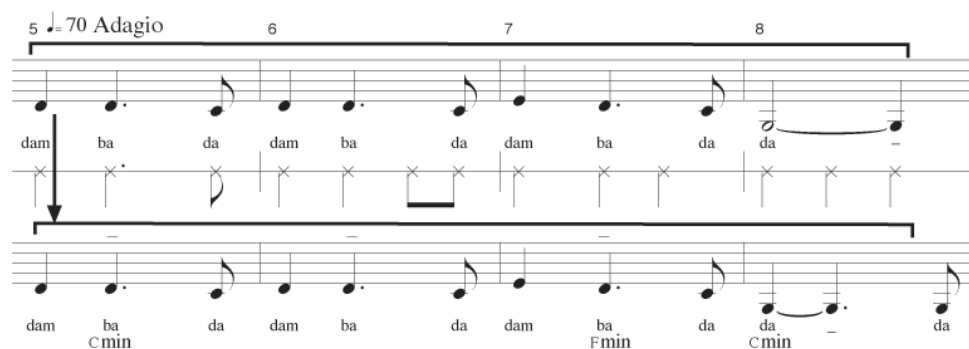


Figure 8.33 *Patient and therapist in unison*

#### EXPRESSIVITY

In bar 8 the patient reaches her full vocal tone. Accordingly she changes the musical expression of her rhythmic accompanying voice from bar 5 onwards, with the start

of the calmer adagio section; the accompanying voice now emerges again – like in Episode 5 – in a calm basic beat and the ostinato accompanying figure.

Her imitative vocal entry in bar 10 shows that she maintains her full vocal expression up to the end and lets it fade out on one breath. From bar 9 to 13 there is a musical modulation to C-major (corresponding major tonality). The delayed vocal entry suggests that the patient anticipates the modulation to the major key. Both vocal voices ring out on the note 'g'; i.e. they combine the minor dominant with the fifth of the new tonic. The patient thus contributes significantly to the change in mood and the opening towards the major tonality with her expressive vocal tone.

In this episode, the patient integrates her rhythmic and vocal actions, which she relates to the therapist's melody voice in the function of a lower accompaniment. She expands her range of action step by step, while simultaneously expanding her expressive potential.

The intensive tonal expression stimulated before by the therapist by a quick tempo, which appeared prior to episode 6, might have been the basis for this change and 'played out' by the patient bringing about her new change of expression. In the therapist's personal comments, her impression of the patient is that she is saying, 'I am able to find my way.'

## **Creating form and influencing the musical context (Episodes 7 and 9)**

### *Creating form and influencing the musical context: Episode 7*

Episode 7 shows the beginning of the second improvisation from the second session. The patient plays with a stick on the metallophone. She has the pentatonic scale available with an ambitus of  $c^1 - a^2$ . The therapist accompanies her on an upper register:  $c^2 - c^4$  on the claves (see Figure 8.34). This ratio of registers corresponds to that in Episodes 5 and 6, where the patient has chosen the lower voice in accompaniment of the therapist's higher melody voice. Episode 7 is characterized by the categories intuition, action and relation.

#### INTUITION

At the start of the improvisation, the patient spontaneously strives upwards with a glissando (see Figure 8.35). With this melodic excursion into the 'unknown', she builds up her rhythmic-metric basis (see quaver sequences and accented quarter notes) and establishes her andante tempo as a secure platform from which she can experiment. Her spontaneous glissando indicates an instinctive grasp of the instrument's specific tonal potential.

Figure 8.34 is a musical score for a session. The top system shows the Patient (Metallophone) and Therapist (Chime bars) parts. The Patient's part is a melodic line in 4/4 time, starting with a tempo of 80. The Therapist's part is a sparse accompaniment. The bottom system shows a piano (P.) and theraphone (Th.) section. The piano part has numbered measures (2, 3, 4, 5, 6) and the theraphone part has a more complex rhythmic pattern.

Figure 8.34 Episode 7

### ACTION

The type of her vocal conduct belongs in this category. She moves up and down in step progression, in accordance with the pentatonic scale constellation. A contrast is the ascending tonal leap from  $c^1$  to  $f^2$ , as the interval of the eleventh. On the basis of this vocal conduct she forms core motifs to be combined to motive forms on a higher level (see Figure 8.36).

Figure 8.35 is a musical score for a session. It shows a melodic line in 4/4 time, starting with a tempo of 80. Two downward arrows point to specific notes in the melody, indicating points of interest or contrast.

Figure 8.35 Intuition

Figure 8.36 is a musical score for a session. It shows a melodic line in 4/4 time, starting with a tempo of 80. Brackets and labels identify 'Motive form' and 'core motif' sections. The 'Motive form' sections are marked with brackets and the label 'Motive form'. The 'core motif' sections are marked with brackets and the label 'core motif'.

Figure 8.36 Core motifs and motive forms

In bar 2 the patient discovers her metric structure (4/4) and starts to interpret melodically. She then begins to develop these motive forms spontaneously (see Figure 8.37).

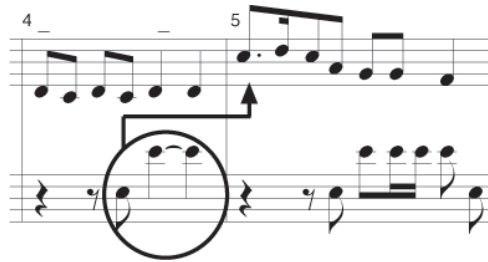




*Figure 8.37 Motive forms and their development*

#### RELATION

The intramusical relation is revealed in the patient's play in the development and combination of the core motif and the motive forms. In conjunction with this, she varies the rhythm in bar 5 (quaver dot on the first beat), which leads to an animated impression. This might also be due to the rhythmicized octave in the therapist's voice in bar 4 (see Figure 8.38).



*Figure 8.38 Animated rhythmic form linked to rhythmicized octave*

The patient often uses tonal repetitions as a starting point for a new melodic movement. The motive forms she generates have a centred tonal direction that is confirmed through repetition. Her independently generated motive forms are logically musical and related to each other in a meaningful way.

In Episode 7, the patient performs a melody within the tonal limitations of this instrument, seemingly effortlessly. From the very start of the episode, she opens up her tonal range, first from  $c^1$  to  $d^2$ , then a second time with a leap from  $c^1$  to  $f^2$ . She does not hold back but becomes active, creating her personal musical–melodic context. The therapist's respective comment from her own notes about the patient is that the patient appears to say, 'I open up.'

The creative motive forms are animated two-measure forms, with a distinctive stress on the beginning. The melodic contour of her motif forms has a balanced direction. A melodic accent is often evened out with a descending line (see Figure 8.39).

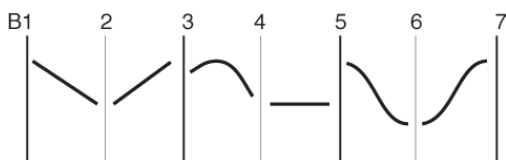


Figure 8.39 *The melodic contour of the motive forms*

The patient develops a security in the style and content of her music that encourages her in her melodic creative interpretation. The tonal repetitions serve not only as orientation but also as a starting point for her new motive forms. This form-giving influence on the melodic development allows the therapist to withdraw to an accompanying ostinato.

These musical characteristics in the patient's play are important as they reveal the patient's experience of herself in a continuous flow of creating and interpreting. This experience is relevant to her insofar as the underlying tendency is to look forward, so that she discovers new, individual possibilities of being.

### *Creating form and influencing the musical context: Episode 9*

It must be born in mind that Episodes 7 and 9 together form one of the patterns emerging from the grid analysis. Both belong to the group of two we call 'creating form and influencing the musical context'. The episode in between, Episode 8, belongs to a different pattern where other musical characteristics are revealed that are part of a different category entitled 'development of musical parameters'.

The categories of Episode 9 are action, relation and expressivity (see Figure 8.40). They are interconnected musically and extend evenly over the entire episode.

#### ACTION

This episode again reveals the patient's ability to find her personal melodic expression without help or considerable musical support. As we have seen in the previous episodes, she benefits from her rhythmic integrity. In a peaceful andante tempo she establishes her own metric ground that gives her security.

The rhythmic–melodic core motif in this episode has two functions: it provides stability, and also – in the patient's repetition – constitutes the starting-point for its melodic expansion. This becomes apparent in bars 1–4, 5–8 and 11–14. Bars 1–4 are an example (see Figure 8.41).

The four-measure phrases formed in this way combine to form phrases of eight and six bars respectively in the further course of the episode. This tonal interpretation of a melodic idea is also illustrated in the two-measure sections with pedal-point

♩ = 100 Andante

1

Patient (Metallophone)

*pp*

Therapist (Chime bars)

7

P.

Th.

13

P.

Th.

*mp*

19

P.

Th.

Figure 8.40 Episode 9

♩ = 100 Andante

*pp*

core motif

Figure 8.41 Rhythmic-melodic core motif

motifs, in contrast to the melodic parts. The therapist's musical influence comes into effect here; she supported her patient's melodic play with the pedal point in Episode 7.

The pedal-point sections appear in bars 9–10, 15–16 and 23–24. In the patient's voice they function as a contrast, but on the other hand also as a transition, since they combine the melodic phrases, as may be seen in bars 8–11 (see Figure 8.42).



Figure 8.42 Pedal points as basis for transition

#### RELATION

The core motifs and motive forms the patient generates constitute the personal communication aspects with which she establishes a musical reference to herself. This reference may be demonstrated within Episode 9 and also between Episodes 7 and 9 through their motifs and motive forms. The rhythmic constellation of the motifs is the same. As a consequence of the new tempo, it is notated in crotchets and quavers only in Episode 9 (see Figure 8.43).

Core motif Ep. 7, first part:

Core motif Ep. 9, Bar 1:



Motif form Ep. 7, Bar 3:

melodically extended motif Ep. 9, Bar 7:



Figure 8.43 Core motifs and motive forms that become extended

This inner reference to her own creative play becomes obvious in the way the patient generates and melodically forms her motifs. She is thus able – as described in the action category – to generate forms on a higher level which give her musical utterances an inner coherence.

Core motif and melodic motive forms constitute aspects of communication in the patient–therapist relation as well. Starting from her pedal point, which establishes the tonal basis, the therapist takes up the patient's core motifs and melodic motif forms (bars 2–5). In bar 4, the core motif appears in a mirror form (see Figure 8.44).

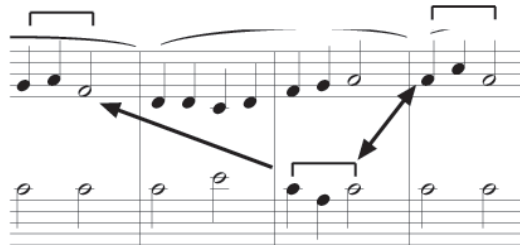


Figure 8.44 Core motifs as mirrored form

This interpersonal relation is also apparent in bars 13–18. Here the patient, with the change to the pedal point (bars 15–16), takes up the accompanying function to the therapist's melodic play.

This close patient–therapist relation revealed in the mutual exchange of melodic and contrapuntal elements extends up to the end of this episode (see Figure 8.45).

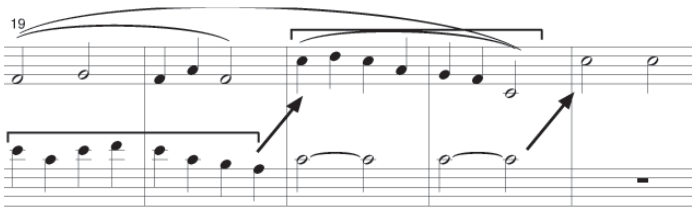


Figure 8.45 Exchange of contrapuntal elements

### *Expressivity*

The patient's skills of interpretation are again very obvious in this episode and serve to express herself in a peaceful, soft melodic manner. The therapist experiences her in a very authentic way, not only in the true expression of herself, but also in her relation to her as therapist.

This episode reveals the patient's inner motives and realities. Episode 7 has already shown the patient's effortless melodic interpretation. We see that melody is the element she can actively shape and express. Compared to Episode 7, she takes one step further here; she generates more comprehensive forms (units of eight or six bars) and adds new and contrasting sections. She intervenes in the musical relation with more energy, with a will to lead. We may say that the patient plays and shapes her musical relation with the therapist independently. The therapist has the impression that the patient has established self-confidence and confidence in the therapeutic relation and subsequently is able to enjoy her own actions and activities in that relationship. For the therapist, this episode sounds like a mutual 'I listen to you and what I play is you.'

## Development of musical parameters (Episodes 8, 10 and 11)

### *Development of musical parameters: Episode 8*

Episode 8 is part of the three-element pattern from the grid analysis and has similarities with Episodes 10 and 11. This episode is again concerned with the categories action, relation and expressivity (see Figure 8.46). The meaning, however, is different in this context; it is the development of musical elements. The question is how the musical elements emerging in Episode 8 become evident in action.

Figure 8.46 is a musical score for Episode 8, written in 4/4 time with a tempo of 100 (quarter note). The score consists of three staves: Patient (Metallophone), Therapist (Chime bars), and Piano (P.) with a Thymus (Th.) part. The Patient staff starts with a forte (f) dynamic and a triplet of eighth notes in bar 3, marked 'subito p'. The Therapist staff has a similar triplet in bar 3. The Piano staff has a crescendo (cresc.) leading to a forte (f) dynamic in bar 5. The Thymus staff has a triplet of eighth notes in bar 3.

Figure 8.46 Episode 8

### ACTION

The tonal repetitions introduced by the patient in bar 3 (see Figure 8.47) help her to develop an independent thematic statement that does not become clearly visible until later.

Figure 8.47 is a musical score showing a triplet of eighth notes on a single staff, marked 'subito p'.

Figure 8.47 Tonal repetition

At first, she chooses a musical change to interrupt her previous two-measure mode (bars 1–2). This change announces a dynamic development, with a rhythmic–interactive play with the therapist up to a culminating point in bar 6 (see Figure 8.48).

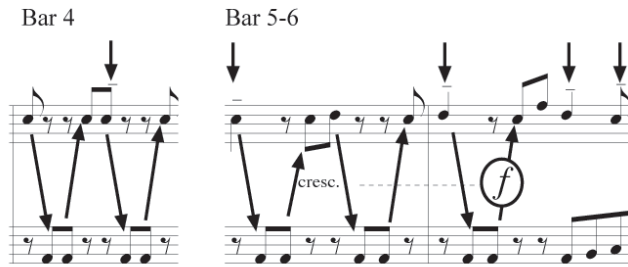


Figure 8.48 *Rhythmic interactive play*

Gradually she builds up her thematic voice out of this interactive play when she leaves the tonal repetitions ( $c^2$ ), changes over to the upper second  $d^2$  and finally goes to the upper fourth  $f^2$  (see Figure 8.49).

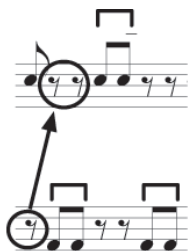


Figure 8.49 *Developing thematic voice*

#### RELATION

Here we have to ask again how the musical elements developed in Episode 8 become apparent in the category relation. An obvious example is the pattern of interaction generated by the patient in exchange with the therapist (accent on the second crochet, with gradual dynamic intensification; see Figure 8.50).

The pattern of interaction emerges from the quaver rest the therapist introduces in bar 4, interrupting the chain of quavers and thus leading to the subsequent complementary 'dialogue' between patient and therapist. For the 'dialogue' the therapist chooses the lower fifth ( $f^1$ ). At the end of Episode 8 both meet on the same note ( $f$ ).



*Figure 8.50 Interaction*

### EXPRESSIVITY

In this episode, the patient's emotional expressivity is bound to the melodic–thematic gestalt she created. The starting point is the note  $c^2$  she chose; from this she forms the melodic intervals that she combines in a meaningful shape. She stresses the interval of the fourth, which is of specific significance here. The fourth is the interval with a strong signal effect (see Wanderer songs, dancing-tunes, or hunting signals) and appeal. The patient's thematic gestalt also signals a distinct statement with a dynamic (forte, accent) and positive outward direction. It appeals immediately to the therapist and calls upon her to join in.

The most important characteristic in the patient's music is her changeover to the leading melodic voice that is expressed clearly. She develops it out of the rhythmic interaction and combines it with her tonal–dynamic interpretation. The dense tonal fabric between patient and therapist reflects their close relation in simultaneous and complementary play. In their joint music-making, the patient experiences herself through the therapist (and vice versa). The experience of one of her inner realities is disclosed in this episode as an expression of will-power that becomes manifest in the form of her melodic gestalt. A positive force makes itself felt in this way that turns away from her illness and focuses on her potentials. The therapist's personal comment is that the patient is saying 'I make a decision.'

### *Development of musical parameters: Episode 10*

Episode 10 is part of the pattern from the grid analysis linking Episodes 8 and 11 (see Figure 8.51). It constitutes the chronological development of Episode 9, and is the last episode of the second improvisation from the second session.

The categories action, expressivity and relation again are relevant in this context, and their significance has to be assessed from the perspective of change.



The musical score for Episode 10 consists of two systems. The first system features the Patient (Metallophone) and the Therapist (Chime bars). The Patient's part begins with a melodic line marked *f*, *agitato*, and *rit.*, ending with a *8va* marking. The Therapist's part provides a tremolo accompaniment marked *stringendo*. The second system shows the Patient playing a melodic line with dynamics *p*, *pp*, and *calando*, and the Therapist playing a tremolo accompaniment marked *8va*. The Patient's part includes fingerings 1, 3, and 3.

Figure 8.51 Episode 10

#### ACTION

Prior to Episode 10, we have a section with animated fast movement and excited and animated expression. The metre is variable. The impulse comes from the therapist's quick tremolo movement in fourth and third. The onset of Episode 10 shows the transition of this quick section to a calmer part with a contrasting expression. The impulse for this musical change comes from the patient. It is interesting to observe how she does it: in a variable metre, she takes the pitch from  $f^2$  downwards to  $c^1$  and ascends again via  $f^2$  to  $g^2$  (see Figure 8.52).

The ascending movement serves to introduce a ritardando in which she allows the notes to fade out longer (rhythmic augmentation) until she inserts the pause on  $g^2$  and thus signals the turning-point. In the therapist's play, the ascending line appears with a delay in the three-line octave range as a reminiscence of the change (see Figure 8.52).

The patient initiates a change of something that is important to her. In order to do so she becomes active, employing the pitch in combination with tempo and dynamics.

#### EXPRESSIVITY AND RELATION

Both categories are combined here. After the turning-point the patient clearly indicates how she intends to go on. She wants a dialogue, very delicate, sensitive, but definite in its statement. She indicates this with a clear melodic motif, opening first the tonal range with a major sixth and then going step by step to  $f^2$ . This melodic statement has a peaceful, intimate expression (slight retardation of the melodic

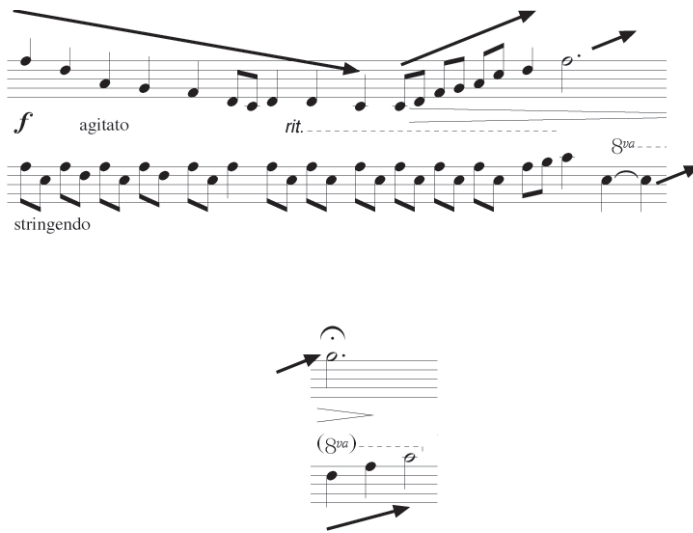


Figure 8.52 Accomplishing musical change

interval of the major sixth). The therapist follows the patient in expression and clarity of melodic statement and responds in the higher octave (see Figure 8.53).

The development in the patient's musical play shows how she uses dynamics, tempo, and variations of pitch and motif to determine her intended form and expressivity. Consequently, she turns the stringent character of the previous music (initiated by the therapist and reaching her as an external demand) into a peaceful, slow mode of play with a dialogic character that radiates nearness and closeness in its intimate expression. She demonstrates her ability to respond to the therapist's interventions by adapting at first but then follows her own inner impulse. Since trust in the therapeutic relationship has now been established, she can follow her own impulse and direct this immediately to the therapist. The latter's personal comment of her impression of the patient is 'I search for dialogue, but in a calm exchange.'

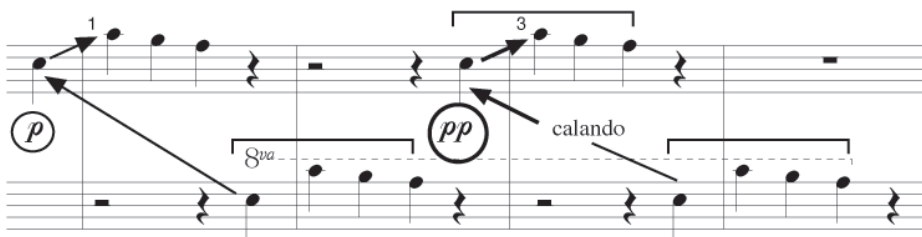


Figure 8.53 Establishing dialogue

### *Development of musical parameters: Episode 11*

Episode 11 is the last example from the triad of the grid analysis. In contrast to Episodes 8 and 10, it is from the third improvisation of the second session. The patient plays the same instrument with the same tonal material, this time, however, with two sticks. The therapist now accompanies her on the piano. Episode 11 starts in the middle and goes on to the end of the third improvisation (see Figure 8.54). In this episode the patient again expands and deepens her relation with those musical principles and parameters that receive their significance through the categories action, relation and contemplation.

The musical score for Episode 11 is presented in four systems, each with a Patient (Metallophone) part and a Therapist (Piano) part. The Patient part is written in treble clef, and the Therapist part is written in grand staff (treble and bass clefs).

- System 1 (Measures 1-6):** The Patient part begins with a tempo of 120 and the marking *Allegro*. The dynamic is *f* with the instruction *spirituoso*. The Therapist part starts with a dynamic of *mp*. The Patient part ends with a dynamic of *mp* and a *sf* (sforzando) marking.
- System 2 (Measures 7-12):** The Patient part continues with a dynamic of *mp*. The Therapist part features a dynamic of *p* (piano) followed by *f* (forte) and then *pp* (pianissimo).
- System 3 (Measures 13-20):** The Patient part includes a *rit.* (ritardando) marking. The Therapist part continues with a dynamic of *pp*.
- System 4 (Measures 21-26):** The Patient part changes tempo to *Andante*. The dynamic is *pp* (pianissimo). The Therapist part includes a *ppp* (pianississimo) marking and the instruction *perdendosi* (fading away).

Figure 8.54 Episode 11

## ACTION

Bars 1–4, 5–6 and 7–8 may serve as examples for action. In the first four bars the patient already reveals her growing skill to vary and develop musical–thematic material. This is suggested by her unconscious use of form-giving principles, like imitation and reflection. She succeeds in bringing her powerful, spontaneous expression into a clear form of two and four measures respectively. The therapist establishes the tonal basis of F-major (pentatonic in the major mode) with the fifth in bass. Moreover, she supports the patient with an alternating note motif (bars 3ff) in adherence to her characteristic triad melody shape (see Figure 8.55).



Figure 8.55 Action bars 1–4

We see in these bars how a musical element introduced by one person may be transferred immediately to another. The octave leap at the end of the alternating note motif in the therapist's voice (bar 4) is taken up directly by the patient and integrated into her emerging motifs (see Figure 8.56). In bars 6ff she adheres to the octave motif, which here is sequenced upwards and thus integrated into an intensified expression. Bars 5 and 6 have the function of secondary bars here and call to mind the contrasting sections in Episode 9. Bars 7–8 clearly illustrate the development of a melodic tie through ascending and descending lines.

## RELATION

The patient takes up the therapist's offer to enter into dialogue in bar 12 (see top section of Figure 8.57). She responds with a melodic motif, taking *f* as a tonal basis, similar to the beginning of this episode. This dialogue begins a new section with a different expressive quality. It goes on to the end of this episode (bar 29) and at the same time constitutes the end of the third improvisation from the second session. In

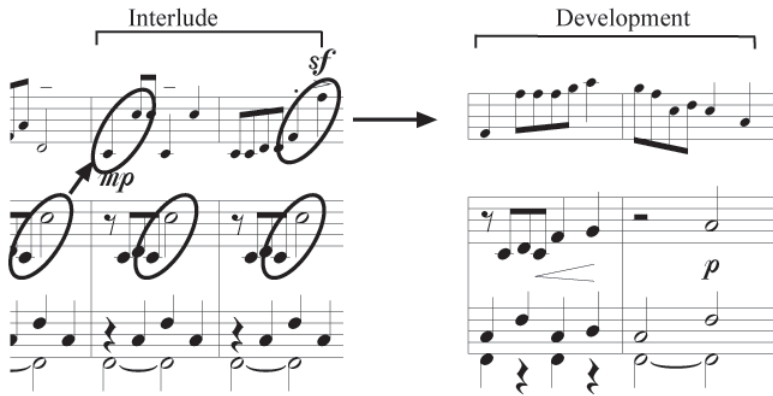


Figure 8.56 Action bars 5–6 and 7–8

this part, both patient and therapist draw nearer to each other in dynamics (mp, pp) and an almost identical melodic statement. The original animated, brisk and playful mode has now assumed a calmer and more collected quality.

In bar 20, the patient announces her intention for the final turn with a descending tonal sequence in ritardando –  $d^2$  to  $c^1$  (see bottom section of Figure 8.57).



Figure 8.57 Dialogue and developing expressive quality

## CONTEMPLATION

*Contemplation* in the context of this study means that the patient has found a chance for inner immersion and simultaneous introspection in musical expression. Her tendency to change over to a calm mode is already obvious in the descending, retarding tonal figure of bar 20. This distinct musical gesture is taken up by the therapist who stabilizes a new and peaceful pace with a three-note motif (see top section of Figure 8.58). This new andante tempo begins the coda covering nine bars where the alternating play between patient and therapist is continued with this motif. The motif is reduced in its melodic–rhythmic movement. It is concentrated on a (single?) sound and may be traced back to the core motif from Episode 9 (compare Episode 9, bars 1–2).

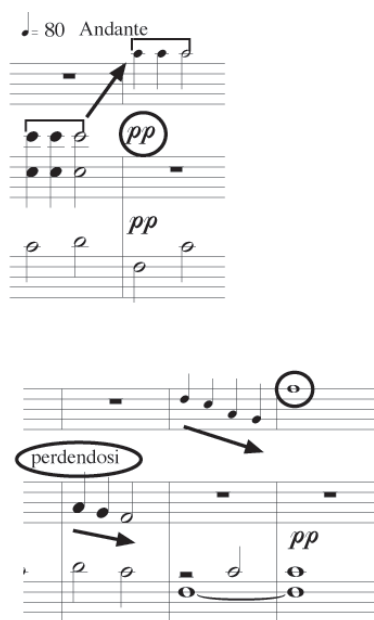


Figure 8.58 Motif and variation: bars 21–22 and 27–29

Subsequently the patient varies the motif in a descending line and gradually reduced volume (ppp). She ends the improvisation when she newly introduces the descending line from  $d^2$  (bar 28) and then transposes the final note in an octave above, i.e.  $f^2$  (see bottom section of Figure 8.58). Although  $f^1$  would be the logical final note from the perspective of vocal technique, the patient opts for the far higher and softly fading-out note  $f^2$ .

Episode 11 reveals the patient's interpretative skills and her delight in taking an active part in the synchronous music-making. In a brisk allegro pace she forms

spontaneously the melodic line in a strong forte. She does not lose control but is supported and guided by her interpretative skills. The dynamically accented octave leaps give an impression of an inner, positive acceptance and affirmation. Her melodic interpretation has a triadic form, with a preference of thirds, fourths and seconds. She appears animated and vigorous, serene, and almost in high spirits.

In the calmer dialogue part introduced by the therapist, the two moments (bars 20, 28) stand out where the patient takes the music to a different level of expression (*ritardando*, slow pace, graduated dynamics in *pp* and *ppp*). As already mentioned, this determines the form of the final turn. The significance of this part lies in the fact that the patient has found an inner balance of nearness and distance in the interpersonal relation, allowing her to get absorbed and immersed in her own music, which we associate with the category *contemplation*. This inner collectedness appears in the concentration on one single element, the ‘final motif’ – bars 21 and 22 (see top section of Figure 8.58). This refinement and careful movement in the patient’s play adhered to up to the end of this episode (the third improvisation) reflects her inner preparedness for contemplation and immersion.

## **Adjusted, restrained play (Episodes 12 and 13)**

### *Adjusted, restrained play: Episode 12*

Episode 12 is from the fourth session and constitutes the end of the second improvisation. The patient plays the bongos with both hands, accompanied by the therapist on the piano (see Figure 8.59).

Episodes 12 and 13 form the pattern of the groups of two in the grid analysis with the meaning of ‘adjusted, restrained play’. Both have therefore something in common with regard to this category.

In Episode 12 the focus is on the category action, while intuition comes to the fore at the end. The question here is what the patient’s adjusted and restrained play has to do with action and intuition in this episode.

### **ACTION**

This episode illustrates the patient’s way to react when confronted with a vigorous mode of expression. The therapist intervenes by approaching the patient with the external demand for guidance and expression. The musical material consists in a close sequence of strongly rhythmicized quaver groups in thirds and fifths in an even 4/4 measure (see Figures 8.60 and 8.61). The expression is determined by this dominant rhythmic–metrically accented interpretation, combined with a quick pace, powerful dynamics, low pitch-level in A-flat major and portato. According to

the variations in which they are used, the quaver groups are marked as bar motif as ‘a’ (bar 1) and ‘a<sup>1</sup>’ (bars 3, 9, 10).

The musical score for Episode 11 is presented in three systems. The first system (bars 1-4) features a Patient (Bongos) part with a 4/4 time signature and a forte (f) dynamic. The Patient part consists of a series of eighth notes and rests, with a bar motif 'a' marked above the first bar. The Therapist (Piano) part is in 4/4 time, also marked forte (f), and consists of a series of eighth notes and rests. The second system (bars 5-8) continues the Patient part with a bar motif 'a' marked above the first bar. The Therapist part continues with a series of eighth notes and rests. The third system (bars 9-12) continues the Patient part with a bar motif 'a' marked above the first bar. The Therapist part continues with a series of eighth notes and rests, ending with a double bar line. The score is written in 4/4 time and includes a key signature of one flat (Bb).

Figure 8.59 Episode 11

The musical score for Episode 12, bars 1 and 3, shows two bar motifs. The first motif, labeled 'a', is a series of eighth notes and rests. The second motif, labeled 'a<sup>1</sup>', is a series of eighth notes and rests, with a bar line above it. The score is written in 4/4 time and includes a key signature of one flat (Bb).

Figure 8.60 Episode 12: bars 1 and 3



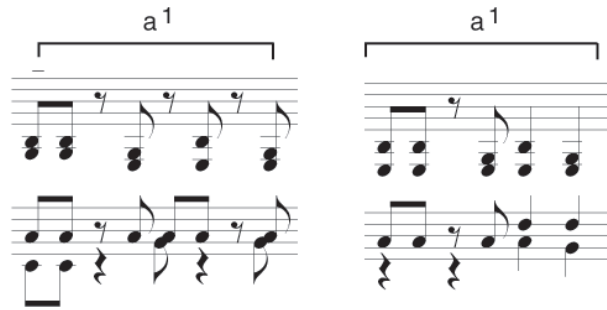


Figure 8.61 Episode 12: bars 9 and 10

The therapist underlines in repetition as an important musical principle. This results in two-measure forms that combine to a higher form comprising four bars: bars 1–4, bars 5–6, bars 9–12. A specific significance in this context is attached to the contrast between the strongly syncopic–rhythmicized movement action (bar motifs *a* and *a*<sup>1</sup>) and the calmer, even movement in the form of basic beats that make the ‘ground’ audible. These calmer measures are marked with the bar motif ‘*b*’. This contrast is most apparent in bars 3–4 and 6–7, for example (see Figure 8.62).

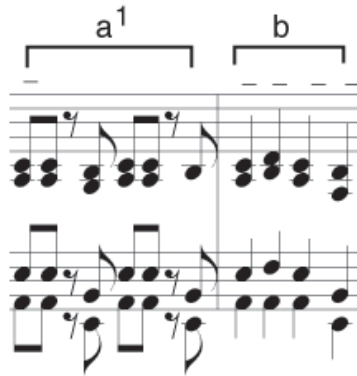


Figure 8.62 Episode 12: bars 3–4

Action shows in the patient’s play in an adjusted and – as to movement – restrained mode of play. This is apparent at the onset of bars 1–2 and in bar 4 (see Figure 8.63).

In a somewhat restrained movement, the patient adjusts to the therapist’s rhythm, following it simultaneously with similar accentuation and dynamic. The expression produced by the therapist is so forceful that the patient is carried away into the flow, as may be seen in bars 6–8 (see Figure 8.64).



Figure 8.63 Episode 12: bars 1–2 and 4 showing motifs 'a' and 'b'

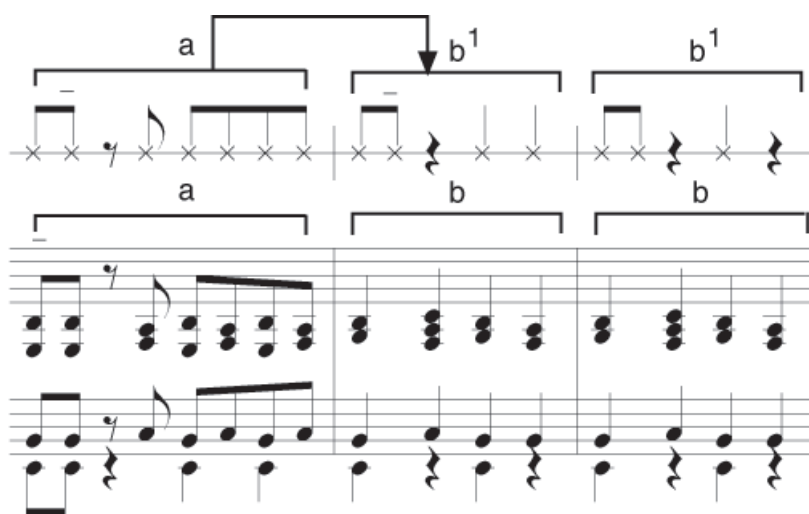


Figure 8.64 Episode 12: bars 6–8

In bar 7 the patient is still influenced by the previous rapid quaver movement (bar motif 'a') that she takes over into the calmer basic beat. While the two quavers appear premature and somewhat uncontrolled, the crochet rest on the second beat suggests that the patient intends to create space and orientation in this new movement. In bar 8, she takes up the quaver motif on the first beat as an independent musical element. She uses the bar motif 'b' in animated variation.

## INTUITION

As early as in bars 9–10, the patient anticipates the final turn of this improvisation announced in the therapist's play by the repetition of the varied bar motif 'a' (syncopated). Emotionally and instinctively the patient perceives the end of this improvisation and in bar 11 responds accordingly with an abbreviated quaver movement and two subsequent crochet rests. These give room to the octave sound in the therapist's voice. At the same time they intensify even more the effect of the accented authentic final sound (bar 12) that the patient performs as a cut-off gesture, simultaneously with the therapist (see Figure 8.65).

This episode indicates that the patient allows herself to be challenged and is able to perform her music-making in an individual style, despite her restraint and adjustment. This is apparent in bars 9 and 10 where she opposes her own voice to that of the therapist (see Figure 8.65).

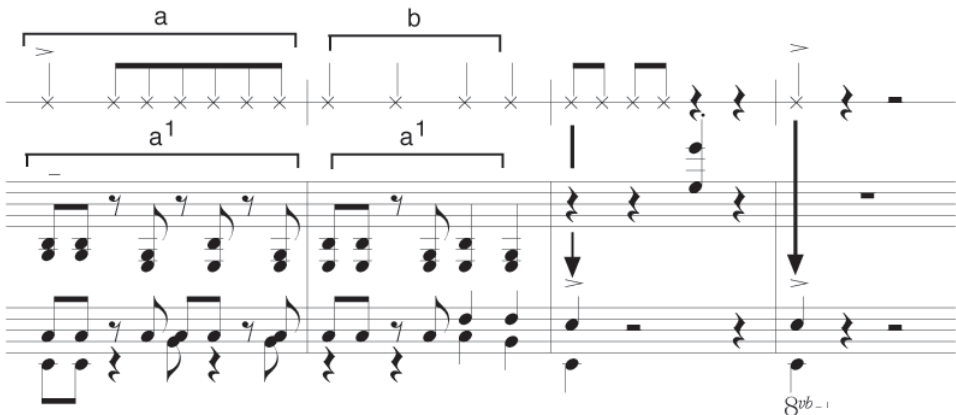


Figure 8.65 Episode 12: bars 9–12

In this episode the patient's relation to the forte is different from Episode 11, where she is able to combine her melodic interpretation with powerful dynamics and act independently. This episode is dominated by rhythmic–metric action. The patient performs with both hands. She uses her entire palm for strong accents, mostly on the first beat. With her rhythmic–metric and accented play, she influences the sound directly and thus experiences an exchange of energy in a very immediate, physical way. The therapeutic effect is not only a strengthening of the physical and mental powers but also provides access to her own creative resources, which on her own she

had sought or believed possible. The vigorous play on the drums brings her into contact with an aspect of her self that perhaps she would not have discovered otherwise.

Asked for the significance of this episode for the melody development, we might say it is in the way the patient places the calm and the powerful accents that give the rhythm its vibrating tension. In joint music-making with the therapist, she assumes the leading rhythmic voice and takes it to a higher form in accordance with the two-measure groups. She experiences here, in a concentrated manner, the elements of sound, movement, vibration, accentuation, guidance and form, which also play a role in melodic interpretation.

### *Adjusted, restrained play: Episode 13*

Episode 13 constitutes the beginning of the third improvisation from the fourth session. The patient plays the bongos accompanied by the therapist on the piano, as in Episode 12 (see Figure 8.66).

Episode 13, together with Episode 12, belongs to the pattern of groups of two from the grid analysis characterized by the meaning of 'adjusted, restrained play'. The focus of this episode is again on the categories intuition and action. Accordingly, the connections between action, intuition and an adjusted, restrained mode of play have to be analysed.

#### INTUITION

The powerful final turn of the previous expressive Episode 12 has its effects on the start of the immediately following third improvisation represented by Episode 13. In her hesitation to take the lead and to develop a new music of her own, the patient intuitively opts for a calm tempo at the beginning (*adagio*) in *mezzo piano* and finds her musical way through the interpretation of a two-measure form with two different rhythmic motifs: motifs 'a' and 'b' (see Figure 8.67).

The patient overcomes the slight instability of her start when she puts the main accent on the first beat in bar 2 and introduces structuring quaver notes. This reveals an inner attitude: waiting, not determined, open for what may come, willingness to adjust and to change.

These two first bars resemble those of the first improvisation from the second session represented by Episode 1 (see Figure 8.68).

In both episodes she expresses her susceptibility to the form of two-measure groups and her interpretative ability with various motifs, allowing them to correspond with each other. Repetition and complementation are the musical principles she uses for orientation and also to ensure her 'ground for improvisation'.

1  $\text{♩} = 70$  Adagio

Patient (Bongos)

Therapist (Piano)

5

P.

Th.

9  $\text{♩} = 110$  Allegro

P.

Th.

13

P.

Th.

*mp*

*mf*

*f*

*stringendo*

The musical score for Episode 13 is presented in four systems. The first system (bars 1-4) is marked 'Adagio' with a tempo of 70 beats per minute. The Patient (Bongos) part is in 4/4 time, starting with a series of eighth notes and a rest, followed by more eighth notes. The Therapist (Piano) part is in 4/4 time, starting with a whole note, followed by a half note, and then a quarter note. The second system (bars 5-8) continues the Patient part with eighth notes and the Therapist part with a half note and a quarter note. The third system (bars 9-12) is marked 'Allegro' with a tempo of 110 beats per minute. The Patient part is in 4/4 time, starting with a series of eighth notes and a rest, followed by more eighth notes. The Therapist part is in 4/4 time, starting with a half note, followed by a quarter note, and then a half note. The fourth system (bars 13-16) continues the Patient part with eighth notes and the Therapist part with a half note and a quarter note. Dynamics include *mp* (mezzo-piano), *mf* (mezzo-forte), and *f* (forte). The instruction 'stringendo' is used in the second system.

Figure 8.66 Episode 13

$\text{♩} = 70$  Adagio

a b

*mp*

The musical score for Episode 13, bars 1 and 2, shows the Patient (Bongos) part. The tempo is marked 'Adagio' with a tempo of 70 beats per minute. The part is in 4/4 time and starts with a series of eighth notes, followed by a rest, and then more eighth notes. The dynamics include *mp* (mezzo-piano). The score is divided into two sections, 'a' and 'b', by brackets.

Figure 8.67 Episode 13: bars 1 and 2

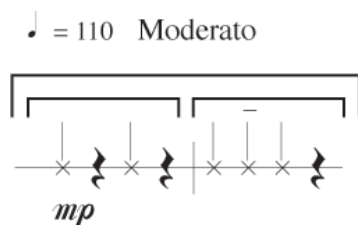


Figure 8.68 Episode 1: bars 1 and 2

In rhythmic correspondence with the patient's two-measure structure, the therapist develops a two-measure motif group that subsequently develops into an eight-measure theme (bars 3–10) in pure D-minor.

The characteristic of this two-measure motif group is the ascending fifth (bar 3) with the subsequent alternating tone motif in descending line – bar 4 (see Figure 8.69).

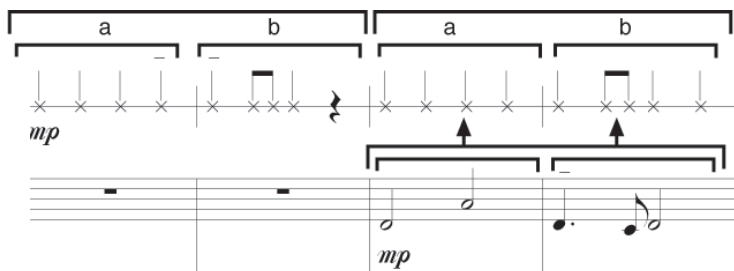


Figure 8.69 Episode 13: bars 1–4

This two-measure motif group that expands further on to an octave forms the basis of the theme. As to sound, this theme has neither a leading note tension nor a dominant tension. In the melodic line, the intervals of the fifth, the octave and the second are dominant, integrated into an alternating tone motif. All melodic intervals appear with a pronounced reference to the basic note d and thus give an overall impression of calm and security.

#### ACTION

Action becomes apparent in the patient's play from bar 7 onward (see Figures 8.70 and 8.71), when she turns away from her two-measure form and replaces it by lining up her rhythmic motif 'b' and its varying intensification (bar 9).

This adjustment and change in the patient's play is triggered by several musical alterations. The therapist expands the fifth motif to the octave and includes a

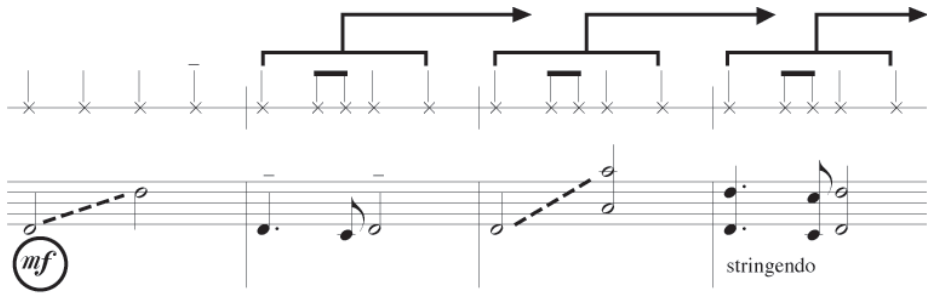


Figure 8.70 Episode 13: bars 5–8

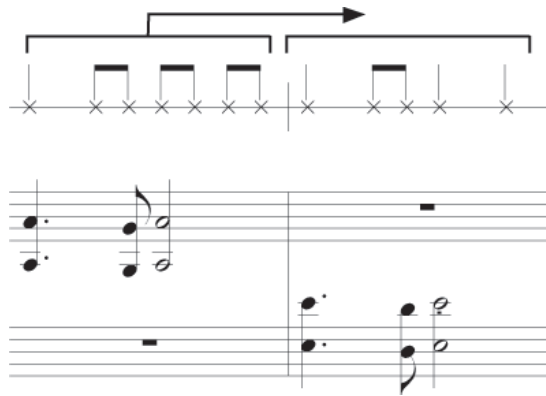


Figure 8.71 Episode 13: bars 9–10

two-voice structure, changes to a higher register that goes over to bass subsequently, and expands the entire tonal range, as well as intensifying volume and tempo. The patient guides her music very deliberately to the renewed onset of the theme in bar 11, in close musical contact. Action is also revealed in bars 11–16 in the sense of adjustment and change.

The repetition of the theme in bar 11 brings a quicker basic tempo (see Figure 8.72) and the patient produces this new and intensified expression with a new two-measure group with two different, yet complementary, rhythmic motifs – ‘a’<sup>1</sup> and ‘b’<sup>1</sup>. This opportunity for change and adjustment on the patient’s part, through new forms of activity, always occurs in close connection with the musical context created by the therapist (intensification of expression through dynamics and bass accompaniment).

The musical score for Episode 13, bars 11-12, is presented in three staves. The tempo is marked 'Allegro' with a quarter note equal to 110 beats. The top staff shows two rhythmic motifs, 'a¹' and 'b¹', with arrows indicating specific notes. The middle staff features a dynamic marking 'mf' and a note. The bottom staff features a dynamic marking 'f' and a note. The score is divided into two measures by a bar line.

Figure 8.72 Episode 13: bars 11–12

The significance of Episode 13 has to be seen in connection with Episode 12. The patient is able to organize her metri-rhythmic idea. She ensures the 'ground' for her musical action when she decides on a two-measure form as the basis of her music. A characteristic element of her interpretation from Episode 1 is again apparent in this context. It illustrates her specific two-measure forms that consist in different, corresponding rhythmic motifs.

In this episode, the therapist's external influence (premature onset, urging pace) again affects the patient's play. But here, this influence is more apparent in the action of changing her musical material, not so much in the dynamic-accented interpretation. The patient uses one of her rhythmic motifs 'b' and develops it in accordance with the musical context.

The patient's action emerges from her adapting but open attitude, which shows restraint in terms of dynamics. She is able to go back to her creatively produced rhythmic motifs, to form them again (see  $a^1 + b^1$ ) and change them to a different expression (see *allegro*). Creativity in this sense reveals the patient's ability to create something original and to free herself.

### Turning into an independent and active partner in music-making (Episodes 14, 15 and 16)

#### *Turning into an independent and active partner in music-making: Episode 14*

Episode 14 is connected through the category 'turning into an independent and active partner in music-making' and is taken from the third improvisation of the fourth session (see Figure 8.73).



$\text{♩} = 130$  Allegro

Patient (Bongos)

Therapist (Piano)

5  $\text{ff}$

9  $\text{mf}$

13  $\text{mp}$

17  $\text{mp}$

21  $\text{mp}$

The musical score is written for two parts: Patient (Bongos) and Therapist (Piano). The time signature is 4/4, and the tempo is marked Allegro with a metronome marking of 130 beats per minute. The score is divided into six systems, each beginning with a measure number (1, 5, 9, 13, 17, 21). The Patient part is represented by 'x' marks on a single staff, indicating bongo hits. The Therapist part is a piano accompaniment, with the right hand (P.) and left hand (Th.) staves. Dynamics include *ff* (fortissimo), *mf* (mezzo-forte), and *mp* (mezzo-piano). There are triplets in measures 17, 21, and 25. A '8va' marking is present in measure 9, indicating an octave shift. The score ends with a final measure in system 6.

Figure 8.73 Episode 14

The categories action, expressivity and relation play a role in this episode, so that these categories have to be analysed against the background of the patient turning into an independent and active partner in music-making.

#### ACTION AND EXPRESSIVITY

*Action* and *expressivity* are closely related in this episode and thereby gain a more substantial meaning. The musical content of this episode is determined by a development part that reaches a first step of intensification in bar 7 and from there goes on to a culminating point in bar 10. After this culmination the previous intensification is gradually reduced and in bar 15 reaches a playful part concentrated on rhythmic patterns with a high level of interpretative precision. The therapist determines the musical context, and the impulse for transformation also comes primarily from her. Despite this external impulse, the patient develops an inner energy that actively influences and decides the musical process. This is apparent in bars 4–10 (see Figure 8.74).

While the patient interrupts her ‘basic beat’ to the therapist’s continuous fourth chords in bar 4 with quarter rests (see Figure 8.74), she takes the lead from bar 5 onwards: she intensifies her accents, her dynamics, and in bar 6 triggers the next step of intensification with a concentrating quaver movement. She thus builds up the musical intensification successively in her very own way. Her expressive quality is determined by her will and energy and has something of a possessive, insistent component.

In bar 6 the therapist joins in the quaver movement introduced by the patient and syncopates it subsequently in combination with a continuous ascent from  $c^3$  to  $a^3$ .

Action in the patient’s play also becomes apparent in the further progress of this episode, in her sustained conduct of voice and stringent, powerful expression.

In close contact with the therapist’s descending, syncopated upper voice (reduced gradation) she slightly lowers her volume and articulates her play so that its contents become more precise. She demonstrates her awareness of form in the three powerfully performed quarter beats in bar 16 in conclusion of the previous section (see Figure 8.75).

#### RELATION AND EXPRESSIVITY

*Expressivity* and *relation* emerge in the last bars of this episode; they, too, are most closely connected (see Figure 8.76).

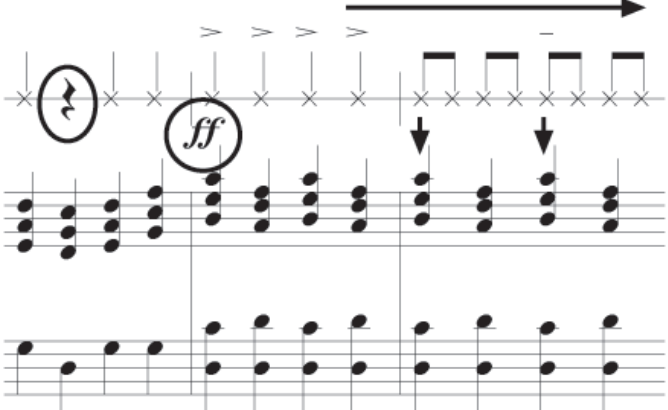
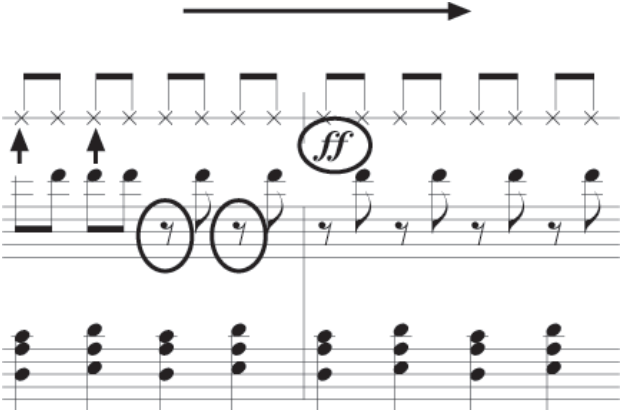
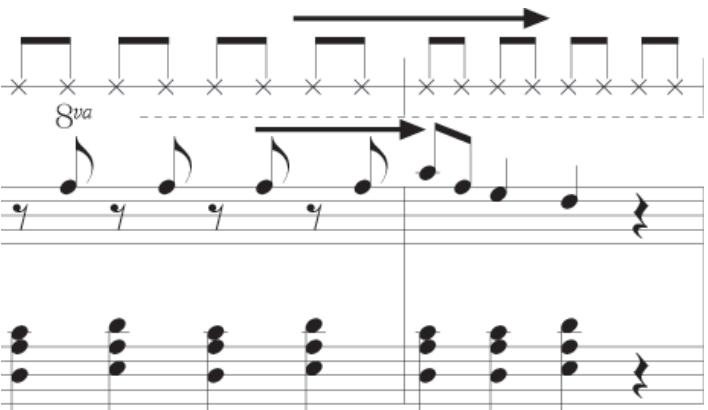
Bars 4–6	
Bars 7–8	
Bars 9–10	

Figure 8.74 Episode 14: bars 4–10



Figure 8.75 Episode 14: bars 13–16

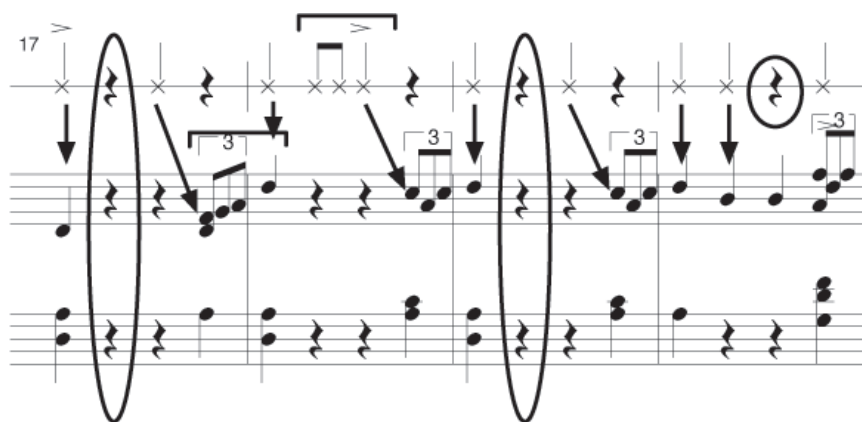


Figure 8.76 Episode 14: bars 17–20

The musical core statement of this rhythmic section is a triplet motif with an added quarter note introduced by the therapist and in closer succession from bar 21 onwards (see Figure 8.77).

An animated activity on the part of the patient is apparent here, with self-confidence and in close contact to the therapist. The expression is vigorous and shows a positive serene mood. She supports the effect of the quarter rest jointly with the therapist (see bars 16, 18, 19 second beat), but appropriately takes up the triplet motif just once (see Figure 8.76).

In this episode the patient reveals perseverance and energy. In her intensive 'insistent' mode of play, she connects the musical sections and takes the lead with vigorous expression. She succeeds in transforming her built-up and pent-up

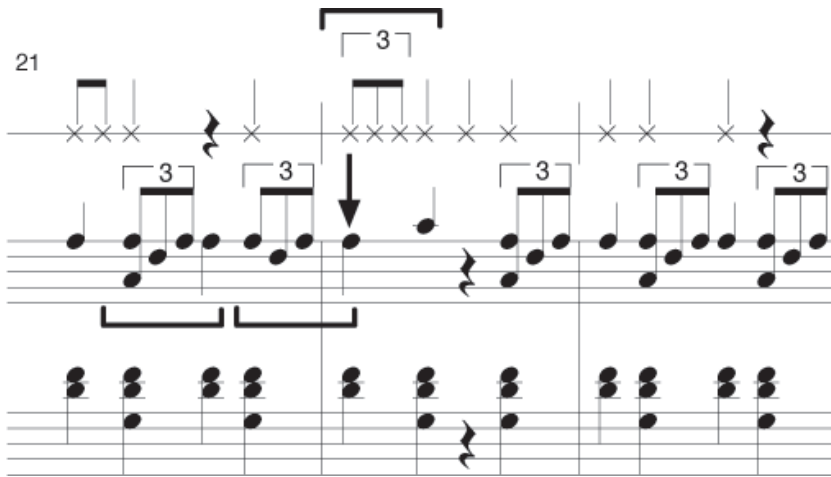


Figure 8.77 Episode 14: bars 21–23

powerful mode of play (bar 17, Figure 8.76); in doing so she demonstrates emotional as well as musical flexibility.

In conjunction with the vigorous expression the patient accomplishes a turn towards independence and self-determination. Her intra-musical relation to form makes this possible. Musical development takes the form in this phase of exploring possibilities, and anticipating musical processes and their consequences. We see this in the way she develops her own rhythmic motifs and musical logic. In the interactive and interpersonal process she plays an active part within the close network of musical relations.

### *Turning into an independent and active partner in music-making: Episode 15*

Episode 15 concentrates on the final part of the third improvisation as closing sequence and is very short. This episode must also be seen against the background of the development towards an independent and active partner in music-making. Its categories are action and expressivity. Action evokes the specific expressivity of this episode, whereby the inner urgency and impulse for strong expression acts vice versa on the action (see Figure 8.78).

#### ACTION AND EXPRESSIVITY

The final turn announces itself in the musical material in the therapist's voice when the strict measure structure dissolves. Three fourth chords lead to an accented octave sound d in the high register of the three-line octave, and after a not clearly defined rest to the octave sound c through a tremolo movement in the bass and the top part.



Figure 8.78 Episode 15

The tonality is ambiguous, since there are no prevailing leading note and dominant tensions.

The patient anticipates the final turn and changes over to an expressive final roll. Despite the open harmonic guidance and the interruption by the rest, the patient does not allow this to influence her. From the beginning of the roll she intensifies the volume continuously until she has reached the appropriate moment for her final down-beat (see Figure 8.78).

The patient reveals her persistence and energy. Her creative force is closely connected to her emotional power. She expresses herself in the sense of being alive, being part of the situation, being committed to the world (tremolo, agitato). The autonomous and stringent way in which she performs her final intensification demonstrates her increasing independence and self-determination in the musical relation with the therapist.

The end of this episode suggests that this final intensification also triggers a catharsis. This final roll the patient produces, intensifying continuously, expressive and unrelenting, challenges her physically and mentally. The impression is that she must play out her energy in order to reach her personal conclusion that – after the strong down-beat – dissolves in a strongly exhaled ‘Pfh’, like a cleansing effect (see Figure 8.78).

### *Turning into an independent and active partner in music-making: Episode 16*

Episode 16 is the beginning of the fifth improvisation in the fourth session. The patient has three percussion instruments in front of her; a big drum, a side drum and cymbal (see Figure 8.79). She uses two drumsticks and the therapist accompanies

♩ = 90 Andante

Patient (cymbal)

Patient (small drum)

Patient (big drum)

Therapist (Piano)

*p* *gliss.* *decisio*

2

cymbal

small drum

big drum

Therapist

*mf* *mp* *p*

6

cymbal

small drum

big drum

Therapist

*p*

The musical score is divided into four systems. The first system shows the Patient playing cymbal, small drum, and big drum, and the Therapist playing piano. The second system starts at measure 2 and continues the Patient's drumming and the Therapist's piano accompaniment. The third system starts at measure 6 and shows more complex drumming patterns and piano accompaniment. The fourth system continues the piece, with the Patient's drumming and the Therapist's piano accompaniment. The score includes dynamic markings such as *p* (piano), *mf* (mezzo-forte), and *mp* (mezzo-piano). Performance instructions like *gliss.* (glissando) and *decisio* (decision) are also present. The tempo is marked as Andante with a quarter note equal to 90 beats per minute. The key signature has one sharp (F#).

Figure 8.79 Episode 16

continued on next page

The musical score is divided into four systems, each spanning four measures. The instruments are cymbal, small drum, big drum, and Therapist (piano).

- System 1 (Measures 10-13):** The cymbal has rests in measures 10-11 and cymbal crosses in measures 12-13. The small drum has eighth-note patterns in measures 10-11 and rests in measures 12-13. The big drum has eighth-note patterns in measures 10-11 and rests in measures 12-13. The Therapist plays a melodic line in the right hand and a bass line in the left hand.
- System 2 (Measures 14-17):** The cymbal has cymbal crosses in measures 14-15 and rests in measures 16-17. The small drum has eighth-note patterns in measures 14-15 and rests in measures 16-17. The big drum has eighth-note patterns in measures 14-15 and rests in measures 16-17. The Therapist plays a melodic line in the right hand and a bass line in the left hand. Dynamics include *pp* (pianissimo) and *mf* (mezzo-forte).
- System 3 (Measures 18-21):** The cymbal has rests in measures 18-19 and cymbal crosses in measures 20-21. The small drum has eighth-note patterns in measures 18-19 and rests in measures 20-21. The big drum has eighth-note patterns in measures 18-19 and rests in measures 20-21. The Therapist plays a melodic line in the right hand and a bass line in the left hand. Dynamics include *pp* (pianissimo) and *mf* (mezzo-forte).
- System 4 (Measures 22-25):** The cymbal has cymbal crosses in measures 22-23 and rests in measures 24-25. The small drum has eighth-note patterns in measures 22-23 and rests in measures 24-25. The big drum has eighth-note patterns in measures 22-23 and rests in measures 24-25. The Therapist plays a melodic line in the right hand and a bass line in the left hand. Dynamics include *mf* (mezzo-forte).

Figure 8.79 Episode 16 continued

continued on next page



The musical score for Episode 16 continued is presented in two systems. The first system covers measures 26 to 30, and the second system covers measures 30 to 34. The instruments are cymbal, small drum, big drum, and Therapist (piano). The key signature is one sharp (F#) and the time signature is 2/4. The score includes various musical notations such as rests, notes, and dynamic markings (*mf*, *ff*, *sfz*). The cymbal part features a series of 'x' marks indicating cymbal strikes. The small drum part features a series of '▲' marks indicating drum strikes. The big drum part features a series of '▼' marks indicating drum strikes. The Therapist part features a series of notes and chords, with a prominent *ff* marking in measure 28.

Figure 8.79 Episode 16 continued

her on the piano. Episode 16 is the last episode of study 1 and together with Episodes 14 and 15 forms part of that pattern of groups of three entitled 'turning into an independent and active partner in music-making'. This episode therefore constitutes the end of the melody development over the course of the therapy period.

With 34 bars, this episode is one of the longest and most comprehensive episodes of the first study. The categories emerging here are decision, action, relation and expressivity. As these categories appear singly, but also in combination with another category, they are analysed successively in accordance with their chronological order within this episode.

#### DECISION

The category decision starts with bar 1, preceded by a short section that illustrates how the patient starts to play. She explores all three instruments in a soft intonation (glissando). In doing so she is quite open and not fixed on a specific metre. Her perception and concentration are primarily directed to the tonal differences of her instruments and the contrast of deep and high sounds. An ornamental motif emerges

as a clear rhythmic element, first played on the big drum, to explore the tonal possibilities (see Figure 8.80).



Figure 8.80 Ornamental motif

The way she lets this motif ring out on the big drum and side drum is striking, somewhat arbitrary and playful. The therapist takes up this open and sound-related character of the patient's mode and integrates it into a cautious monophonic whole-tone music.

The patient tries to tune into this tonal contrast with the help of this ornamental motif which she alternates with a crochet (see Figure 8.81).

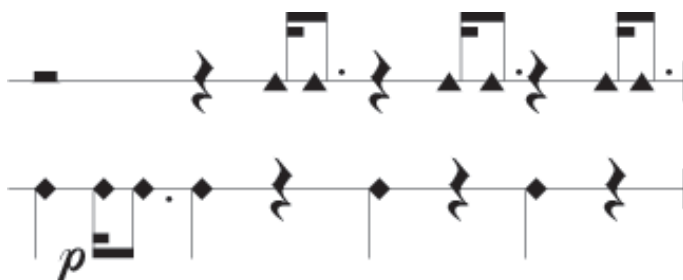


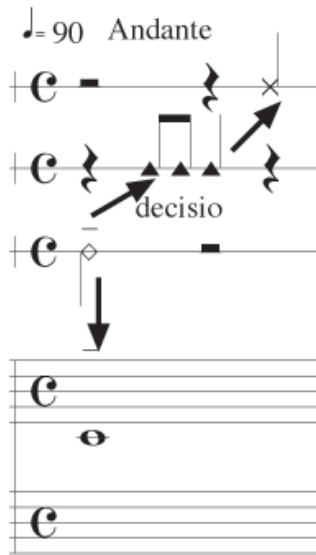
Figure 8.81 Integration of the ornamental motif

This open beginning is the precondition for the category *decision*, because the patient gives herself the necessary space to prepare for the improvisation. This turn towards decision becomes clearly audible from bar 1 where she relinquishes her open probing mode and tackles something definite in tempo, metre, structure and intonation (see Figure 8.82).

Bars 1 and 3 show a clear metre form with a clear rhythmic pattern. This rhythmic pattern is the basis for bars 1 to 6 (see Figure 8.83).

The patient distributes this pattern over the three available instruments and varies her form in each bar so that no two bars sound alike. With the exception of bar 6, she takes the main accent (first beat) always on the big drum (see bars 1 and 3, Figure 8.82). The frequent alternation between instruments produces simultaneously fluctuating sounds and allows the patient to evoke new accents and thus to

## Bar 1:



## Bar 3:

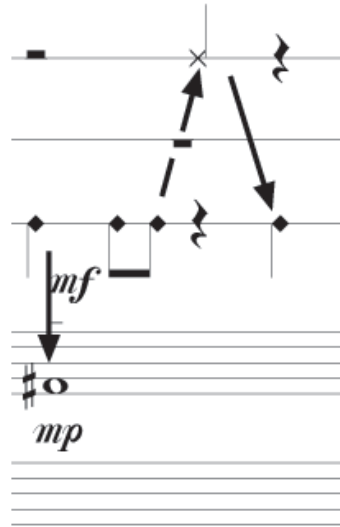


Figure 8.82 Episode 16: bars 1 and 3



Figure 8.83 Episode 13: rhythmic pattern for bars 1–6

enrich and liven up the entire sound image. In bar 1 she develops a tonal sequence starting from the big drum leading via the middle register of the side drum to the light cymbal. This sequence underlines the tonal accents of the first and fourth beats. In bar 3, she contrasts the deep sound with the high cymbal sound, so that the first and third beat are accented.

This category illustrates that the patient uses her sensitivity to tonal phenomena for her performance and thus determines the music. As soon as the patient clearly turns towards decision, the therapist starts to accompany each bar with one whole note. She concentrates on the tonal moment and the tonal relations, which in their sequence underline the colourful, atmospheric character of the whole-tone music.

This tonal sequence is repeated and varied in the following bars and may therefore be seen as the key theme which has an integrative effect on the cohesion in the patient's and therapist's music-making (see Figure 8.84).



Figure 8.84 Episode 16: tonal sequence bars 1–4

#### ACTION

Bars 5–8 indicate a more deliberate action in the patient’s play. She ‘sequences’ her basic rhythmic form from the deeper to the higher timbre and in bar 7 concludes with three quarters on the light cymbal sound (see Figure 8.85). This repeated action suggests the patient’s ability to have a form-giving influence on the music. She draws conclusions from what she has played and turns them into musical logic: three quarter beats on the cymbals form a caesura, a clearly audible cut. The patient thus indicates that something new might be in the offing.

This caesura effects the therapist’s play. She starts from her key motif and develops a new whole-tone motif integrating the patient’s basic rhythmic form. In addition to the rhythmic structure it shows a wave-like internal movement (see Figure 8.86).

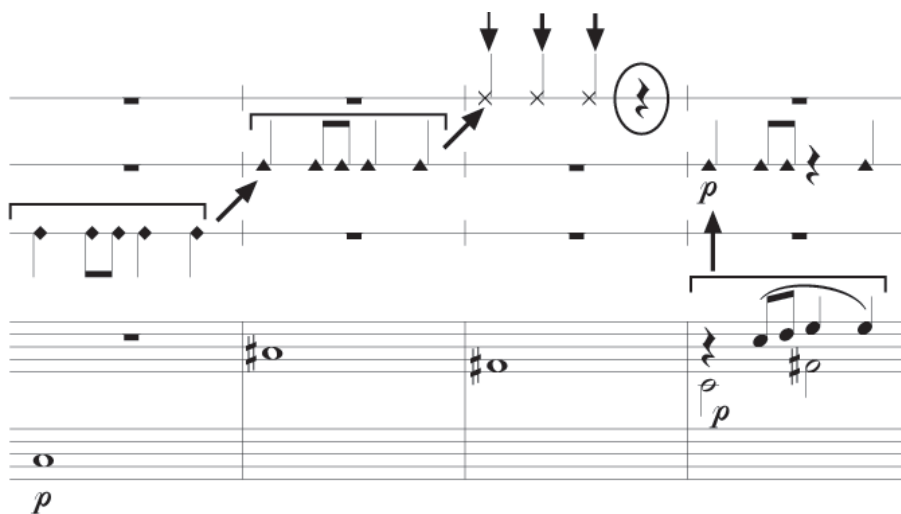


Figure 8.85 Episode 16: sequence of rhythmic form bars 5–8

In its clearly differentiated two-voiced design it is like a dialogue moving between the calm basic theme stretching over several bars and the more animated second voice that ascends and descends.



Figure 8.86 Episode 16: whole tone motif, bars 8 and 9

#### RELATION AND ACTION

Relation and action appear closely interconnected in bars 11 to 19. Patient and therapist make synchronous movements without giving up their own identity. This close relationship is illustrated as follows.

In response to the therapist's flowing wave movement, the patient changes her basic rhythmic form in bars 11–14 into a corresponding quarter movement and shortens it successively up to bar 14. For the first time, the cymbals ring out on the first beat in tonal contrast (see Figure 8.87). The supporting whole notes in the therapist's voice constitute the tonal–thematic frame for the musical action of both persons involved.

Figure 8.87 Episode 16: tonal sequence bars 11–14

In the section covering bars 15–19 (see Figure 8.88), the patient no longer vacillates between drum and cymbals but changes over to the side drum (bars 14/15) and thus

takes the initiative for new action. This decision manifests itself in bars 14/15 in her rhythmic upbeat figure in mezzoforte (see Figure 8.89)

Figure 8.88 Episode 16: tonal sequence bars 15–19

Figure 8.89 Episode 16: rhythmic figure bars 14 and 15

In the subsequent bars 16 and 18 she goes back to her rhythmic form of bar 11 and contrasts this with calmer varied beats on the cymbals. The rhythmic upbeat figure initiated by the patient has a signal effect and influences the therapist's play. From bars 15/16 onwards, she integrates the upbeat motif into her rhythmic structure and changes over from her previous polyphone dialogue into a homophone voicing where thirds and augmented fourths prevail.

#### RELATION

This category is significant in bars 25–27 since as it illustrates the connection with the theme and the melodic motif in the therapist's voice (see Figure 8.90).

The outstanding melodic motif is the upbeat ascending augmented sixth with the subsequent major third ringing out on  $\text{fis}^2$ . It announces itself first in bars 23/24. This motif is of a distinctly inviting nature. In connection with  $\text{c}^2$ , the note  $\text{fis}^2$  becomes part of the tritone. After its melodic alternation with  $\text{e}^2$ , it stands out again in bar 27.



Figure 8.90 Episode 16: bars 25–27

The patient refers to the melodic motif, complements it first on the cymbals, and then in bar 27, with three striking quarter beats on the big drum. These beats meet the note *fis*<sup>2</sup> in each case, so that we might imagine the melodic line shown in Figure 8.91.



Figure 8.91 Episode 16: completed melody line, bar 27

We speak again of a signal effect caused by the patient in bar 27 that influences the further course of the episode. Immediately afterwards, this effect evokes the two categories *expressivity* and *relation*, promoting bar 27 as the one that announces a change in expression.

#### EXPRESSIVITY AND RELATION

In bars 27 to 31 the therapist takes up the energy projected by the patient's three quarter notes and repeats the melodic line with a dynamic (*ff*) and harmonic intensification of expression (see Figure 8.92).



Figure 8.92 Episode 16: bar 27–31



The patient consistently sticks to her chosen course. In close connection with the melodic–thematic progress, she repeats her rhythmic form with stronger expression. She achieves this through an accent on the cymbal (first beat), a vigorous forte and an altogether increasing intensity in her play. This intensified expression reaches a *sforzato* in bar 31.

The significance of bar 27 may also be seen from an excerpt covering the last bars of this episode (see Figure 8.93). The intensification of expression is continued here. The therapist's music assumes the character of a march. The theme construction appears in chord blocks with a bass ostinato in fortissimo. The patient varies her rhythmic form in favour of her own expressive intent: her 'crochets' now ring out in a forceful, vigorous forte, stressed by the change to a parallel mode of play.

Figure 8.93 Episode 16: bars 31–34

Considering the patient's rhythmic material in her specific choice of instruments, we can see that she ascribes different degrees of rhythmic significance to them. Frequently she associates the big drum with an accented beat and a dense rhythmic sequence (see Figure 8.94). The side drum repeatedly shows the easy formation alternating between 'heavy' and 'light'.

In accordance with the echoing character of the cymbals she associates with them not so much rhythmic motifs but rather single beats which she carries out in different ways, corresponding to her formal interpretation (see Figure 8.94).




Bar 11, big drum	
Bar 20, sidedrum	
Bar 7, 14, 22, cymbal	

Figure 8.94 Episode 16: rhythmic material

This illustration alone gives an idea of the patient's skills of differentiation. When she changes instruments she sometimes takes her time with rests on the fourth and first beat (see bars 7, 17, 19, 24, 26, 27). The impression is that she permits herself sufficient scope to be able to perform the change in sound deliberately.

In this episode, the patient is able to combine openness and determination. She manages to employ both in her play independently of the therapist.

At the onset of the episode, the focus is on the tonal experience in the patient's play. She explores and expands it with ever-new sound structures involving all three instruments. The patient enables herself to perceive the different sound formations, occasionally maintaining a specific rhythmic form that provides stability, safety in listening, and enjoyment. She is again able to find a balance between two opposing elements: the invariant and the variant. For her, this means being able to stay with something, to let something go on, but also to change and vary something.

She employs her interpretative skills with the expanded tonal range. As to sound and interpretation, her form-giving powers become most obvious in caesuras and final turns. These show dynamic-innovatory tendencies and produce and carry on new expressive heights until she has reached her full expressive power (see bars 31ff, parallel play in even quarters). She presents it in a confident and self-determined manner. Consequently, the patient is able to vary her rhythmic form in favour of her expressive intent.

We find a suggestion for this dynamic development in bar 27. With the patient's three accented deep beats it calls to mind the symbolic content of the figure 'three'. The figure 'three' is the sign of the triangle and also of the Holy Trinity. It has traditionally played an important part in music. Counting one-two-three has always been considered the perfect basic metre. It also found corresponding expression in formal interpretation ('Barform'), in the triad, and the octave, which apart from being itself, is also the product of fifth and fourth (Blume 1989a). We may speculate here that the patient has also harmonized something within herself; externally through the three

different instruments with their specific timbre and tonal differentiation from deep to medium range and high; internally through her integrity of action, relation and expressivity, which she presents in a coherent manner.

## Integrating Episodes and the Melody 'A Walk through Paris'

This chapter is about discovering the connections between episodes and finding out how the episodes relate to the melody of the last session. In addition, we point out the procedural course of episodes as structured interactions in time.

Let us first take a look at the higher level of the therapy development as a consequence of the categories of elements (episodes). A 'map' of the therapy process gives a graphic survey (see Figure 9.1) of the higher level of five episode phases. In this map, we concentrate on the categories of elements (episodes) themselves, on their contents and significance. On the basis of her experience of a musical relationship appearing in synchronous dialogue form and marking the communication phase, the patient is able to integrate her musical play. This means that musical motifs gain significance for her, that she is able to open up internally, to let herself be touched emotionally, and to relate her internal being with external actions. She also integrates the interpersonal relationship with the therapist in her play.

The 'musically integrated play' phase is necessary for the patient to take the 'musical lead'. The favourable experience in this category has helped the patient to gain confidence and thus enabled her to influence the improvisations and give them a direction in accordance with her own expressivity and style. Additionally, this experience provides a valuable basis for the patient. She finds courage to advance, to develop something new. She follows her personal creativity and in doing so has produced an element of melodic quality, that of a leading and guiding voice.

The melody, 'A Walk through Paris', is an example of a comprehensive melodious form, which comprises her personal experience of musical categories in the context of improvisations. Communication, integration guidance, formation and independence are the categories revealed in the expressive substance of their melody.

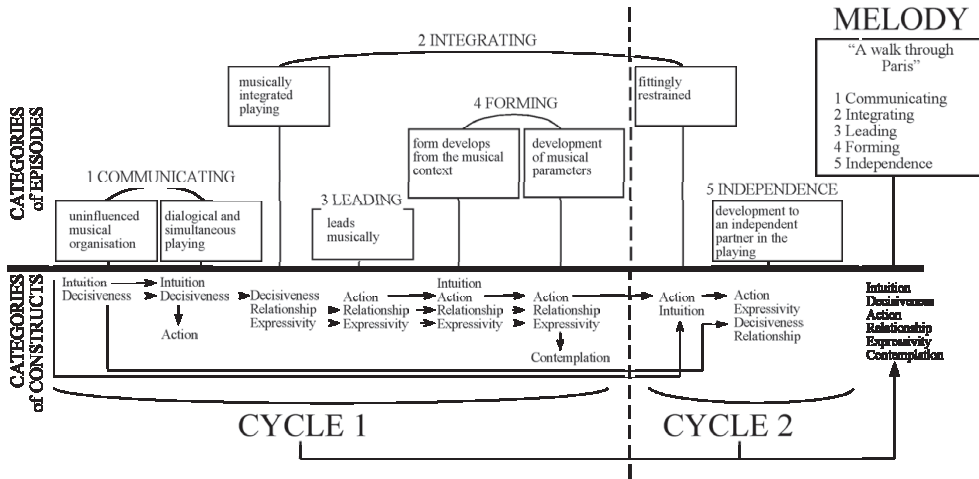


Figure 9.1 Temporal development of the therapy phases according to the categories of constructs and episodes

Now the question is how the patient got from one episode to the next, how she was able to change from one development stage to the next. Here we refer to the categories of constructs that formed the relevant categories of musical analysis. Again we may use a graphic description of the categories of constructs in their association with the therapy course (see Figure 9.1).

Looking at the categories of constructs in their relation to the therapy course, two cycles become apparent:

- *cycle 1* [(intuition, decision) action) relation, expressivity] contemplation
- *cycle 2* [(action, intuition) expressivity, decision, relation] melody.

In the first cycle, the patient combines her intuition with decision, whereby the new category of action emerges. Decision and action lead the patient to the categories of relation and expressivity. Both influence each other, as became obvious in the analysis part. In combination they create a focal point within this first cycle. Over three phases of the therapy, the patient works through them and lives them, alternating with action and intuition. The action category also takes a leading role when the patient takes it up again in the third development stage, and it remains a significant factor in her play to the very last moment.

At the end of this first cycle, contemplation emerges as a new category. The course of this first cycle shows that both categories of relation and expressivity, extending over the first cycle like a keynote, lead to a culminating point which

appears as contemplation. This new category turns out to have a cleansing and refining effect on the patient's musical play.

In the second cycle the patient returns to her intuition. We know that this return to the first category (first phase in the therapy) is related to the therapist's intervention. But this time, her action goes beyond intuition and leads her to the categories of expressivity, decision and relation. In this second cycle, all categories appear in a concentrated form, with the exception of contemplation. The last therapy phase shows that the patient is able to evoke what allows her to become an independent, active musical partner. Obviously, relation plays a minor role in the second cycle. It was negotiated in the first cycle intra- and interpersonally with the therapist and made congruent. In this cycle the patient demonstrates her new independence and self-reliance in active play and a new expressive quality. This cycle immediately turns into the melody, which is carried by the categories intuition, decision, action, relation, expressivity and contemplation.

### **Factors of melody development in the study**

In the therapy of this patient, five phases (communication, integration, lead, formation, independence) characterize the 'stations' where the patient had to 'stay' in order to gain a variety of experiences which continuously directed her to her own melody. She had to pass these stations in order to find expression in accordance with her identity and authenticity. Communication, integration, lead, formation and independence are therefore the preconditions for the melody that was created in the last session.

The way in which she gained experience becomes obvious in the categories of constructs. With a view to the first study, we can see that the patient reached decision and action with the help of her intuition, which enabled her to relate to herself and also to her therapist. She thus came into contact with her expressive self, which expanded her expressive qualities and thus directed her towards contemplation. In a subsequent regression phase she once again returned to her intuition, which this time was influenced by her action. She emerged from this phase with greater strength and employed her action, expressivity, decision and relation for a new quality of expression in a new way. With these categories as the central modalities in the patient's play she formed her melody in the last session. This statement may be substantiated with several musical examples.

#### *Intuition*

The *intuition* category belongs to both cycles. The patient is able to resolve her basic two-measure rhythm with the 'expectative tension' created by the therapist and to

change over to a passage-like continuation (quaver movement), which aims at the culminating point (Episode 2, bars 3–4; see Figure 9.2). *Intuition* becomes apparent in her melodic play in her spontaneous tonal opening of the available sound range, which she combines with a metric–rhythmic basis to establish a calm initial pace (Episode 7 start). This intuitive connection and integration of the individual elements of note, sound, ambitus, direction, metre, rhythm and pace lead to the beginning of her melody in the last session which – like the last-mentioned examples – is sustained by her intuition. This means that the patient has recourse to her inner formative powers and organizes her personal melodic course in a highly independent manner with the help of the iambic measure.

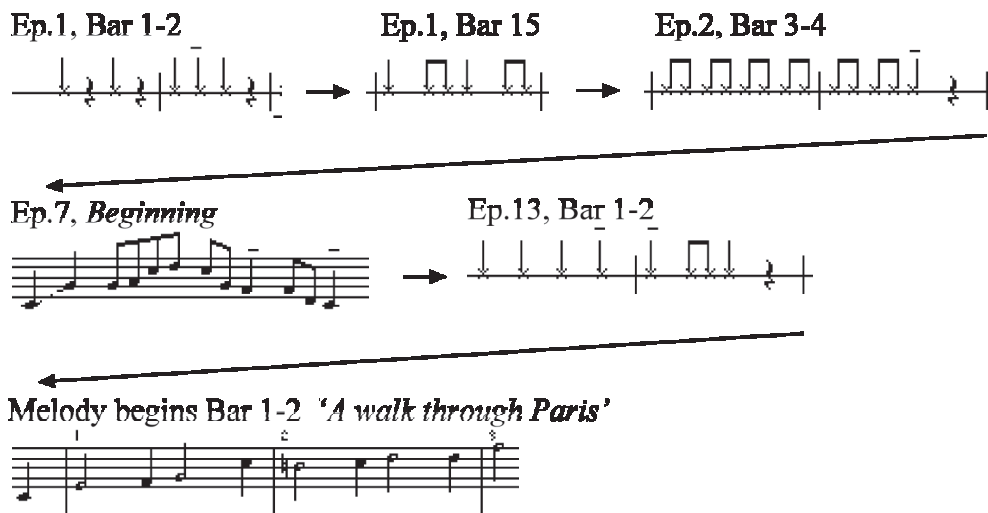


Figure 9.2 Examples of intuition and their development within the five phases

The way the patient starts the melody in the last session indicates the development she has completed. She has decided on a certain melodic course, which she is able to control and clearly articulate. Nevertheless she remains open to other possibilities. This clarity of expression exposes her personality and lends a quality to her inner feeling that is revealed in the consistently unfolding form.

## Action

We have seen that *action* resulted from a combination of the *intuition* and *decision* categories. The musical examples of *action* are frequently characterized by dynamic attributes (compare Episode 2, bars 14–15), thus showing an evident connection with the *relation* and *expressivity* categories. In alternating reference to these categories, *action* appears in the impulse effect of a ritartando (Episodes 6 and 10), a core motif (Episode 7) which later on develops into a four-measure melodic theme (Episodes 9 and 11) or in relation to the therapist assumes a comprehensive rhythmic form (Episode 13, bars 11–16), a subito piano intervention (Episode 8, bar 3), an expressive final turn (Episode 15) as well as an independent sovereign mode of play (Episode 16).

This clearly observable development within this category helps the patient to assume the leading part in the melody of the last session and to underline her expressivity (see Table 9.1).

**Table 9.1** ‘A Walk through Paris’: Start of sections C-F

Start of section C	
Start of section D	
Start of section E	
Start of section F	

## Connections between categories within the first cycle

*Relation* and *expressivity* are the two categories that result from *intuition*, *decision* and *action*, in the first cycle, and finally lead to *contemplation*. In the second cycle, they appear in connection with *decision* and lead over to the melody of the last session.



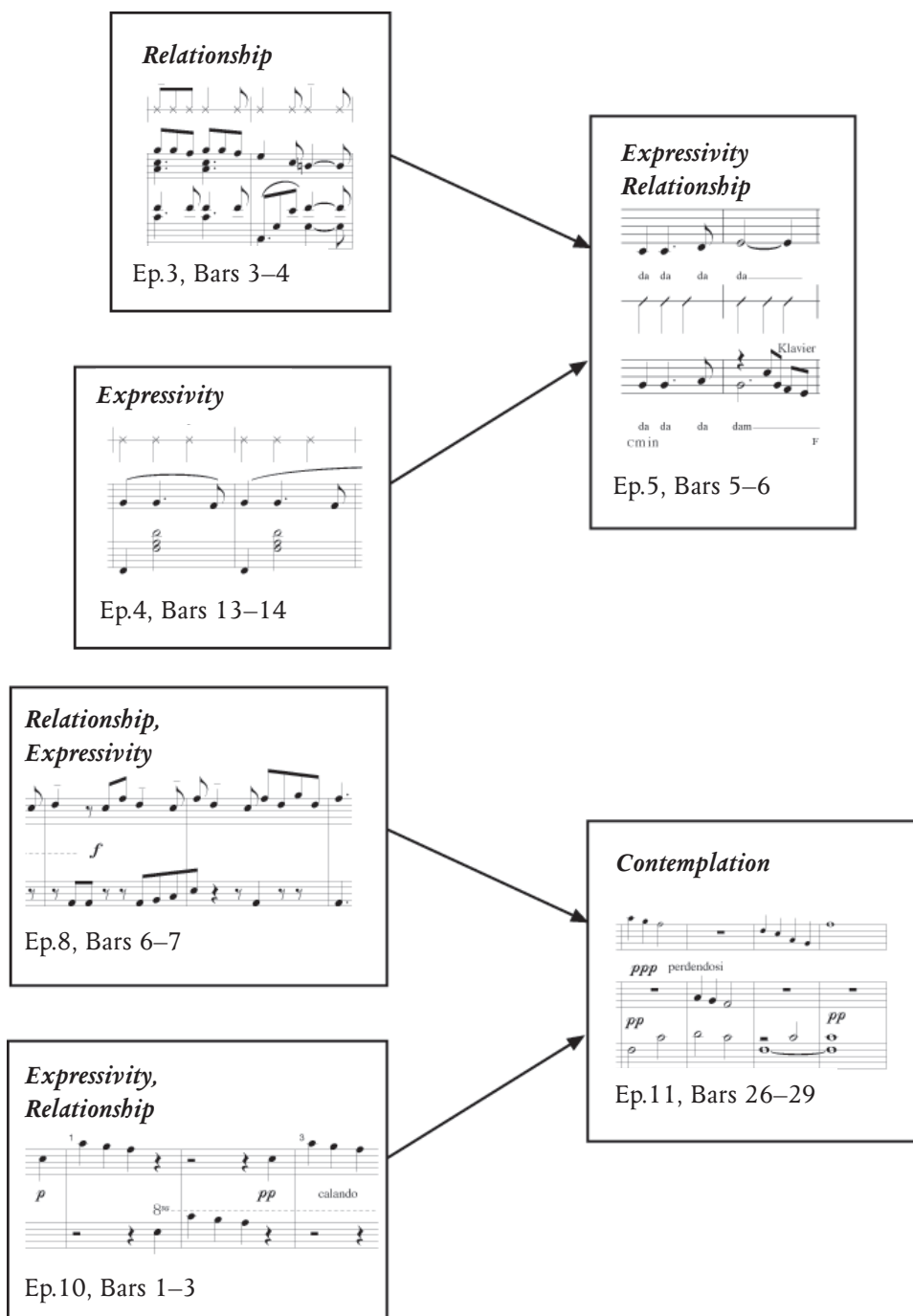


Figure 9.3 Examples of categories and their development within the first cycle

The musical example Episode 3, bars 3–4 (see Figure 9.3), illustrates the interpersonal relationship between patient and therapist in the shared swinging 6/8 metre which appears harmonious in the tonal framework of C-minor. It results in expressivity which becomes apparent in the form of a fuller tonal expression in Episode 4, bars 13–14. Both examples are conducive to a close constellation of expressivity and relation in Episode 5, bars 5–6, whereby the expressivity has a more direct reference to the patient's vocal expression, and the relation may be associated with its intra-musical reference (joining of vocal and instrumental part in expression of C-minor harmonic). All three examples illustrate their position within the higher level of the second development phase that characterizes the patient's integrative play. It influences the subsequent therapy process and becomes obvious in its close constellation in the fourth phase, the content of which is defined by the development of musical parameters. Relation is visible in Episode 8, bars 6–7 (see Figure 9.3), in the interaction pattern which the patient and alternately the therapist intensify gradually and turn into a melodic form. It is this form to which she connects her emotional expression and which she produces in shaping the elements of dynamics, articulation and continuation of motif. In the example of Episode 10, bars 1–3 (see Figure 9.3), the patient deepens her expressivity with the help of the calm dialogue she initiated in her play that evokes the interpersonal relationship. Expressivity in this context refers to tonal relations, in particular to the melodic interval of the expressive major sixth. Both examples contribute to contemplation in Episode 11, bars 26–29 (see Figure 9.3). The descending final motif reveals the inner composure and concentration on one element.

### **Relations between categories within the second cycle**

This chain of relations continues in the second cycle. Figure 9.4 illustrates the development of musical relations.

The second cycle resembles the beginning of the first one. Now, however, action takes the foreground, supported by intuition, and becomes apparent in the example of Episode 13, bars 11–12 (see Figure 9.4), in the form of a two-measure phrase consisting of different, varied rhythmic motifs ( $a^1$  and  $b^1$ ). There is a direct connection from here to expressivity which is revealed in the strong dynamic interpretation in the example of Episode 14, bars 5–6 (see Figure 9.4). Both categories lead via decision (see e.g. Episode 16, bar 1, with a clear time form, motivic character and sound structure) to expressivity, which is supported by relation. The pertinent musical example is Episode 16, bars 26–27 (see Figure 9.4). In close adherence to the development of melody and theme, the patient intensifies her expressive play with rhythmic motifs in the interpretation of sound structure, dynamics and articulation.

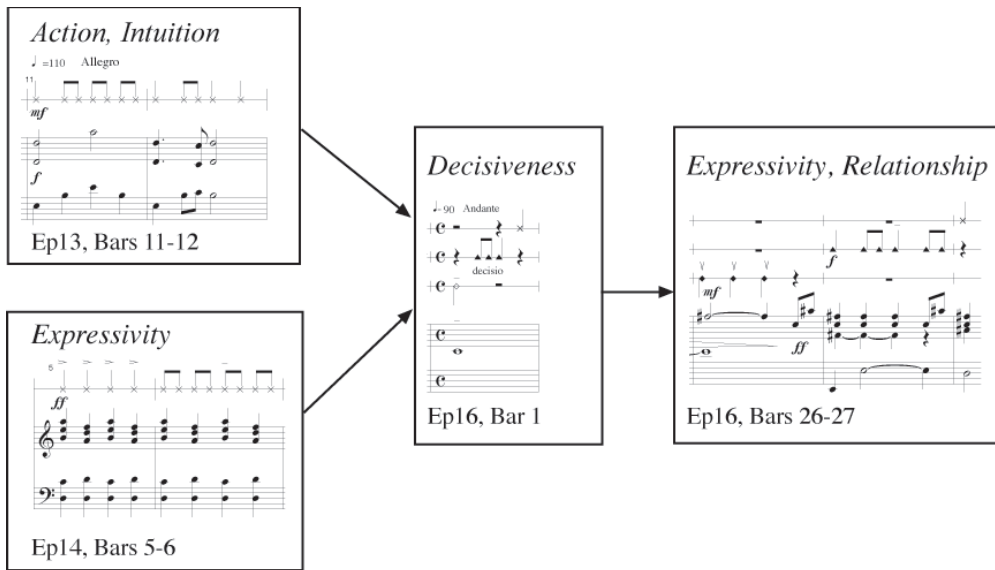


Figure 9.4 The development of musical relations

The second cycle indicates increased dynamics in the course of the therapy; the patient changes over immediately from the integration phase into the independent phase. This individual dynamic development is a consequence of the interaction between patient and therapist.

### Categories of constructs in the course of the melody

Figure 9.5 illustrates examples from the melody of the last session, which combine in their melodic shape what emerged before as categories of constructs in the course of the episodes.

The patient brings her last phase to a conclusion with the interpretation of this last melody, combining the categories of constructs in a similar sequence and constellation as in the course of cycle 2. In a concise form, the unfolding melody reveals its entire therapeutic development incorporating the five previous therapy phases.

The initiation motif, introduced by the patient at the beginning of the improvisation (A) (see Chapter 6, Figure 6.2) turns into a joint pattern of interaction between patient and therapist and contributes to the development of the melodic form. In the course of the melody it changes its form in various respects with regard to relation and connection to categories.

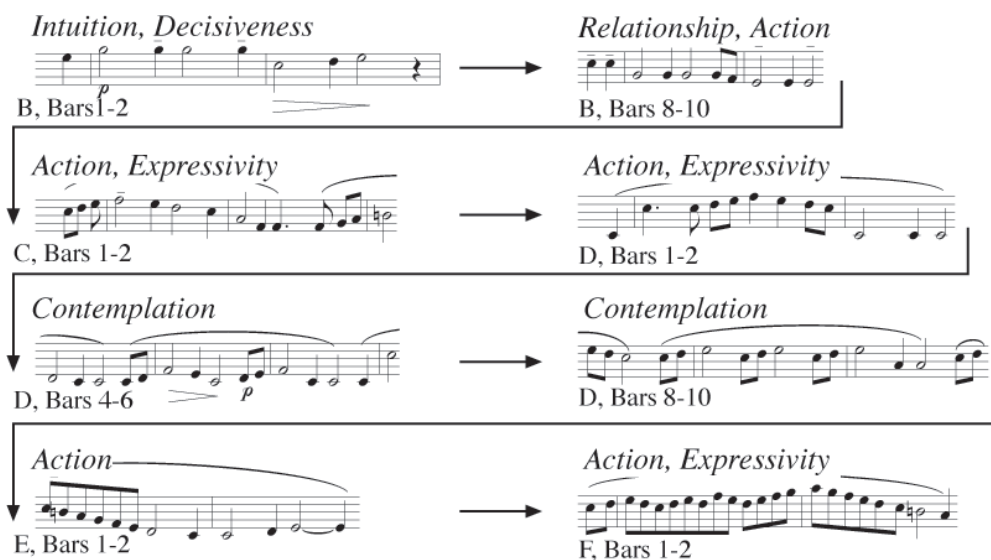


Figure 9.5 Development of categories of constructs, illustrated with the melody 'A Walk through Paris'

The emotional quality audible in the patient's play cannot be eliminated from the musical material she produced, as the latter becomes apparent in a very active and lively manner in the categories of constructs.

We see here that the experience of a melody unfolding in this way is also the experience of a meaningful entirety with a high level of interpretative quality – an emerging melodic creation with more properties than the sum of its single musical elements. In this example, the interpretative qualities may be demonstrated in its graphic form, the synthesis of its elements, and its transposability. It may well be true that the given scale in C-minor with its three half-tone steps (the most important one being produced by raising the seventh note, with the augmented second between the sixth and seventh notes) is the trigger for the patient's freely evolving play. The tonal tension immanent in the scale may have produced her kinetic energy which places each note in a certain power relationship with the others and thus confers to it a functional meaning in the overall process (see Chapter 6, Figures 6.3 and 6.4).

The harmonious reference in the patient's play, in particular to the keynote, suggests that she has found a way of expressing herself that gives her a central focus and also allows her to reorient herself. It may be the significance of the keynote that it establishes this new search for identity and provides a basis for new orientation. That the patient frequently takes up the keynote may be related to finding a new

identity. We are now in a position to understand how the melodic experience has a deep significance for the patient, who has found a way not only to give form to her inner expressivity but also to experience herself more positively, since the melodic experience transferred her to a new and pleasant environment. We know that positive feelings are very important and useful for coping in postoperative treatment. Through her own melody, the patient learns that she is able to create something out of her inner self that is beautiful and aesthetic. Behind the melody there is a personality who experiences herself; despite regarding herself initially as being mutilated she now regards herself as beautiful. This dimension of beauty raises her to a new level of hope, an aspect that is perceived as the motivating power to achieve internal goals (Aldridge 1995; Aldridge 2000). The patient thus opens up new perspectives to overcome her illness and realizes herself as a new transcending personality with the help of her own creative powers.

## The 'Farewell Melody'

This part of the study describes the creation of a melody with a patient of a psychosomatic hospital ward suffering from a functionally somatizing reactive depression. In this context it should be born in mind that the patient's illness is of secondary importance to the study. We are not presenting primarily a study of clinical effect but a study of how a melody emerges, albeit in a therapeutic setting and with potential ramifications for the patient's well-being. Naturally, for the patient and therapist, depression and its alleviation are of importance, but the focus of the study is on the melody itself. Nevertheless, a depressive interlude is the starting point for the musical contact.

### **Therapeutic setting**

Music therapy sessions are influenced by the hospital's philosophy, which becomes apparent in a specific perspective on the definition of illness and health and in the pertinent therapy concepts.

In the context of a ward culture where this study took place, treatment is based on teamwork. The team consists of physicians, nursing staff, arts therapists, physiotherapists and other paramedical staff. Basic treatment concepts are located within a milieu of depth psychology and systemic perspectives of illness and health, all against the background of an anthroposophical view of the person. Health and illness are seen as processes related to individual biographical history and are influenced by biological, psychological and social influences. Arts therapies figure large as integral parts of this concept (painting, music, sculpturing, therapeutic eurhythmics and speech therapy). Other elements used on the ward for therapeutic purposes include fairy-tales or folk dancing. Family members are involved and psychosocial counselling is offered where appropriate.

Treatment presupposes a patient's willingness to accept the therapy and the possible changes involved. A patient's motivation to change has to be made clear and explicit in initial interviews. Patients are requested to describe their complaints and expectations for therapy in writing prior to the first interview.

### **Illness in context**

We must assume that, in principle, everybody can find himself in a situation in life where he reacts with a depression under certain circumstances (Haenel 1986). Although depressive disorders are among the most frequent mental problems (about one-sixth of the population experiences a severe depressive crisis at least once in their lives), there is no consensus among experts as to what depressions are, how they develop and how they should be treated (Eberhard and Eberhard 1997).

In addition, we must consider that views on aetiology and treatment of depression, like other illnesses, depend on the attitudes and culture of a certain epoch. The great variety of approaches over time indicates the insecurity and helplessness in the face of this type of disorder.

Somatic therapies of the twentieth century, psycho-pharmacotherapies developed in the second half of the century and advances in psychodynamic perspectives have contributed towards a better understanding of depression as an illness. In the field of endocrinology in particular, neuro-psychophysiological and chronobiological studies have produced findings that allow a clearer definition of several individual subtypes and have thus gained practical significance (Rose 1991). Despite latest findings and more efficient treatment methods, our understanding of depression as a phenomenon in general must still be called fragmentary and incomplete (Haenel 1986).

### **On the term 'depression'**

In reality, each person experiences a different infinite variety of depressive states. (Dörner and Plog 1984 , p.201)

A search for a clearer definition suggests that the term 'depression' is used to describe a wide range of disorders in feeling, well-being and behaviour (Bräutigam, Christian and von Rad 1992; Dörner and Plog 1984; Kraus 1983; Philipp 1983; Rose 1991). Moreover, it is not always easy to differentiate between a depression requiring medical attention and a normal psychological state of depression and sadness as a reaction to loss or pain. A major problem with the term 'depression' that it is used in a general sense as a construct and also to describe specific behavioural events. The

great number of conditions that evoke the term as a construct are not well-defined (Benesch 1981).

On the level of symptomatology, depression means a state of affective dejection, sadness and low spirits. Repeated efforts have been made to categorize depression's manifold and varying manifestations. Such classifications either refer to the phenomenology (i.e. the manifestation) or to the nosology (i.e. causes and circumstances under which depression occurs). The latter group includes the traditional classification of depression into psychogenic, somatogenic and endogenous depression. There is no comprehensive model to explain the generation of all forms in a satisfactory way (Rose 1991).

### *Psychosomatic aspects*

Interaction between physical and mental state becomes manifest in the psychosomatic and somatopsychic aspects of depression more distinctly than in other areas. Here we can also observe an intertwining of genetic factors and environment, personality and situation, psychodynamic causes and the mental and physical implications of an overriding obsession with an idea (Bräutigam *et al.* 1992). Physical complaints and functional symptoms, as concomitant disorders of a depression, may reach such a degree that they dominate the general appearance of a patient, and the mood changes involved may be easily overlooked. This can happen with all types of depression.

Modern psychoanalysis also supports an integrative concept of interaction, whereby somatic damage like genetic, neuronal, toxic or infectious deficits of the limbic system creates a disposition for dysfunctional psychic forms of coping. In this process, psychic disorders may have a disruptive effect on the biochemical functions of the central nervous system, and vice versa (Eberhard and Eberhard 1997).

Psychoanalysts frequently see depressive patients as dependent on the real presence of usually idealized objects, which also explains their vulnerability to separations (Bräutigam *et al.* 1992). As a consequence of an insufficient differentiation between self and object, later separation experiences often become a psychosomatic problem. Loss of object therefore means loss of self. Organic illness serves to ward off this existential threat. The dependence on an external real object is transferred to the dependence on an inner object, an organ of one's own body, to protect the psychological self. This tendency towards internalization and somatization of mental suffering and external psychosocial conflicts is not only part of the patient's specific illness, but also an element of modern medical technology, whenever areas of psychosocial conflict are neglected.



### *The significance and therapy of depression*

Although some efforts to sub-classify the definition of depression have been quite differentiated, they contribute almost nothing to an understanding of the type, development and significance of the illness for the patient concerned (Eberhard and Eberhard 1997).

The literature quotes general factors with examples for physical and mental symptoms suffered by the patient. Symptoms listed are, for example, general negative feelings, diffuse or burning pains, troubled sleep, tiredness, exhaustion, feebleness, lack of impulsion, apathy and inability to perform, often accompanied by self-recriminations and a feeling of physical heaviness (Bräutigam *et al.* 1992). In addition there are indications of typical situations that may lead to depression, such as changes in a patient's biography which may involve loss of security, separation, isolation and increased responsibility.

Similar factors are listed in the WHO International Classification Code, where symptoms are described as follows (Eberhard and Eberhard 1997, p.15):

In typical episodes of minor, medium or severe degrees, the patient usually suffers from dejection, loss of interest, cheerlessness, and decreased motivation. The reduction of energy leads to increased weariness and restrained activity. Small exertions often result in considerable exhaustion. Other frequent symptoms are:

1. Reduced concentration and attention
2. Reduced self-value and self-confidence
3. Feelings of guilt and uselessness
4. Negative and pessimistic view of the future
5. Suicidal thoughts, self-harming and suicidal acts
6. Troubled sleep
7. Reduced appetite

Similar to manic episodes, the clinical picture shows significant individual variations ... In some cases, temporary anxiety or agony and motor excitation are more evident than depression.

These types of clinical diagnoses and descriptions of the symptoms of depression, however, are 'without history and face' in their presentation and therefore do not give a graphic description of what this illness means for the patient himself. Exploring the meaning and experience not only of depression but also of illness in general, it is useful to fall back upon narrative forms for the patient to tell his history.

It is true that these do not have the substance of a conventional research report, but they impart the dynamic expressivity of a lived language that can touch and move us in its immediacy. This involves the musical qualities of language. 'The essence of language is that of musical form, which is the vehicle for the content of ideas' (Aldridge 1996b, p.100). The content of narratives, similar to that of art, is imparted in the form of their presentation: 'Stories have a metaphorical shape and form which recreate a pattern of being, a pattern of being which symptoms also represent as a metaphorical, albeit restricted, reality' (Aldridge 1996a, p.101). We are able to perceive patterns and understand them on a human level. Obviously, it is not possible to evaluate such narratives with conventional methods alone, as employed in quantified expert language. Therefore, Aldridge proposes a descriptive method, which is to encourage patients to express not only their illness in the hospital setting but also what they feel and experience in everyday life at home and at work. Meanings may thus become evident in their reality. A descriptive science of human knowledge, based on an aesthetic component, might thus be able to express what it means to be human: what it means to feel healthy, and to fall ill. 'These narratives can be understood as being structured according to rules of construction, as are musical compositions' (Aldridge 1996b, p.101).

As depression is so heterogenous in its forms, it is hopeless to search for a generally valid depression therapy that is suited to all existing types. Individual understanding is not the automatic consequence of one general depression theory. Music therapy offers possibilities for the perspectives of relation and clarification. Richard Strauss, for example, uses the transfiguration subject to formally demonstrate the modern concept of introducing a theme as a *Verklärungsthema* in 'Tod und Verklärung op. 24'. The theme is no longer represented but developed gradually, in several stages, eventually reaching its completed *gestalt*. In the course of this musical, developmental process the theme becomes clearer until it eventually achieves adequate expression. A similar process is conceivable in music therapy where a patient may gradually evolve his melody form that triggers off a clarification process in his personal experience.

## Music therapy and depression

Starting the analytical session, you must forget everything you know, and do just one thing: listen as well as possible. (Translated from Eberhard 1997, p.137)

The analyst Jeanne Lampl de Groot heard this quotation many times from Professor Freud. It takes us immediately into the area of applied music therapy and underlines one important aspect which is of significance in both therapy forms, that of

listening. Listening to a patient's narrative of his life, a therapist gets an idea of the patient's dynamic expressivity through spoken language. This comprises pace, phrasing, rhythm, pitch, intonation and sound of speech. We know that these qualities in our speech, which are musical in nature, form the fundamental basis of communication (Aldridge 1996b, p.35) and therefore play an important role in all forms of therapy. They imply something beyond the illness itself. Improvisation in music therapy uses these qualities as a basis for assessment and structure of sessions.

Here again, creative music therapy helps patients give creative expression to their life stories. They express not only their pathologies, but also their potentials as existing factors in their individual life processes. Experiencing both components supports recovery. Creative music therapy encourages patients with depression to express their symptoms, and the emotions and cognition involved, and thus gain an immediate access to their internal mental processes. This form of creative music therapy does not focus on a person's deficits but on the development of individual inclinations and potential and thus provides an opportunity to experience one's own self as 'new' in the moment of musical creation. How a patient forms his identity in creative music-making will indicate how he intends to cope (Aldridge 1996c).

From a relationship perspective, the music therapist shapes her clinical relation, with a client with the help of music as a medium just like a speech therapist who chooses idiomatic language or a specific phrase connotation in order to establish a therapeutic relationship (Pavlicevic 1997).

Traditionally, music therapy has played an important role in the treatment of mental illness. First examples may be found in Greek classical antiquity (Haenel 1986). In the twenty-first century, music therapy is an integral part of comprehensive treatment approaches. The work of Schwabe should be mentioned in connection with practical psychotherapy, as it is based on psychodynamic music therapy methods (Schwabe 1987). Reinhardt and Ficker (1983) advanced Schwabe's method for the treatment of depressive patients with the idea that these patients, when listening to their own music, should be faced with their inner self and their surroundings.

Another contribution to employing creative music therapy improvisations with mental patients was made by Pavlicevic and Trevarthen (1989, 1991). They compared the music made by 15 schizophrenic and 15 depressive patients with that of 15 clinically normal controls. For this purpose, they developed a musical interaction scale with six levels of interaction, from total lack of contact (level 1) to established mutual contact (level 6), to evaluate emotional contact between patient and therapist. A critical element in their opinion was the adjustment of both client and therapist to one joint pulse. Although the therapist succeeded in establishing contact with the group of depressive patients, they seemed to be unwilling to take the

musical lead more frequently. The control group not only allowed musical contact but was even able to take the initiative. In contrast, the group of schizophrenic patients was difficult to approach with music, and idiosyncratic in their mode of play, in accordance with other studies of schizophrenia.

Basically, two factors must be taken into account in active creative music-therapy improvisations: the experience of listening actively – or perceiving, and simultaneous active music-making. The therapist reflects the patient's musical play in the joint, mutual musical exchange. In this constellation, the patient has the opportunity to experience himself in all the aspects of his being (experience) and also in relation to another person (behaviour). We may assume that, in the course of the therapeutic process, the experience of a gradual shaping of one's own self and of the self in relation to another person (therapist) may assume the function of an 'explanation'. The positive part of this process is that the patient may literally hear who he is, how he advances, and how he wants to be or could be. The positive aspect therefore lies within the patient's potential, in his opportunity (and choice) to take the initiative and in no longer having to be depressive. The deficits resulting from depression may thus be 'composed' and thereby rendered 'liquid', i.e. transformed and changed. Any musical element introduced by the patient, or any music behaviour, may serve as a basis for initiative, which may then be evolved with the therapist's support.

### **The patient's clinical situation**

The patient in the second study reported for hospital treatment from his own choice and was referred by a physician. A massive increase in somatic complaints had made hospitalization necessary. Upon admission, the patient is 32 years old, holds the position of a research assistant and is working on his doctoral thesis. He describes his future perspectives as insecure and not well-defined; his wish is to leave the university. He says he lives together with a fellow student, they have a six-year-old son. He is diagnosed with functional somatizing reactive depression. The patient describes his life and his complaints as follows.

From childhood he has suffered from relapsing inflammations of the middle ear, which made two operations for a cholesteatoma on both sides necessary. After further surgery, his hearing is impaired despite hearing aids. This impairment produces considerable mental stress. At the age of 20, he starts having symptoms which do not disappear in the following years; feelings of tremendous inner tension, particularly in situations which demand decisions, accompanied by severe perspiration. In such situations, he tends to frequently change or revise decisions. These tensions have extended to all other areas of life, to his job and home environment, with general feelings of insecurity and anxiety as a consequence. He increasingly

doubts whether his choice of a career was correct and loses self-esteem. At the age of 25, he suffers from increasing muscular pains in his legs, and later, his arms, which he tries to compensate with physical exercise. His general state deteriorates, however. Back pains, head pressure, tremor, vertigo, speech disorders and visual impairments, functional complaints of the digestive system and difficulties in thinking and remembering follow. He realizes that sometimes his speech is incoherent and he cannot focus properly in conversations. He has no positive feelings any more, instead there are frequent states of helplessness and anxiety. His impression is that of sliding down, of breaking up.

He described his expectations and objectives concerning the therapy in an interview as follows. He wants to achieve peace and balance and tackle his problems in a cautious way. In his current state, he feels he has lost control, and body, mind and spirit are in continuous imbalance. He is aware that the recovery of balance requires a considerable effort on his part, but he is willing to do what is necessary. He hopes the therapy will help him to achieve a better understanding of the processes involved in his personal biography. He sees many of his physical complaints as results of the loss of self-esteem, perhaps due to the family history since his father has been an alcoholic for many years. In addition, he hopes that additional arts therapies like painting and music-making will help him to regain his energies. He also wishes to improve his decisiveness. He knows that he has kept his wishes or thoughts hidden too often and for too long. From hospital treatment, he expects help for a fundamental change in his biography that he has not been able to bring about so far.

In the four weeks in hospital, the patient received arts therapy (sculpturing) and music therapy upon personal request. At school he had learned to play the guitar in the classical style and had happy memories of situations where he played together with others. Music therapy sessions were once a week for 45 minutes. The patient had a total of four music therapy sessions.

### **The 'Farewell Melody'**

The 'Farewell Melody' is presented in this section. It was created in the patient's last session and forms the main element of the fourth session. The patient expressed a wish to play the vibraphone. The instrument available has a range of three octaves (f–f<sup>2</sup>). The claves with the respective sound-enhancing metal tubes are positioned in accordance with the piano keys; this allows for diatonic and chromatic play. Instead of the electric motor, which produces the characteristic sounds similar to a vibrato, the patient used the pedal of the instrument which he was able to press down with his foot, to let the individual notes ring out freely. He played the instrument with two felt sticks, and the therapist accompanied him on the piano.

This melody created in the last session is again the introduction to the evaluative process. This section presents the 'Farewell Melody' and reflects on its meaning for the patient. The most significant section of the melodious improvisation of the fourth session is described, which consists of the beginning and the subsequent course of the melody and the final turn. Figures 10.1 to 10.7 are illustrations of these two examples.

The figure displays three systems of musical notation for a Patient (P.) and a Therapist (Th.).

- System 1:** The Patient's staff (treble clef, common time) begins with a melody marked *pp* (pianissimo) and *mp* (mezzo-piano). The Therapist's staff (grand staff, common time) is empty.
- System 2:** The Patient's staff continues with a melody marked *mf* (mezzo-forte), featuring triplets and a *rit.* (ritardando) marking. The Therapist's staff (grand staff) responds with a melody marked *pp* and *mf*, also featuring triplets.
- System 3:** The Patient's staff continues with a melody marked *accel.* (accelerando) and *8va* (octave), featuring triplets. The Therapist's staff (grand staff) responds with a melody marked *sostenuto* (sustained).

Figure 10.1 Beginning of the 'Farewell Melody': bars 1–12

*Beginning of the 'Farewell Melody'*

BARS 1–5 (SEE FIGURE 10.1)

After a glissando ascending twice, played in a very soft, light and superficial style, the patient starts with a four-beat form consisting of two equal bar units. The interval of the fifth (bars 2–3) gives outward form to his descending tonal shapes, which give an indication of the tonal range of E-minor in natural (bar 3) or Phrygian manner with a fading Phrygian second (bar 5). The motif of the third in crochets, articulated by the rests, turns out to be a characteristic element and is supplemented – and also contrasted – by the accelerating group of quavers. The two crochet rests (bars 2,4) have an energetic function in this context, since they increase the expectation in the further course of the initiated form. This latter is reflected in the patient's flighty, strikingly 'casual' tonal sequence. Despite the distinct musical structure, his four-bar form has no integrative, organizing effect but appears lined up 'breathlessly', despite the rests.

BARS 6–11 (SEE FIGURE 10.1)

As soon as the therapist takes up similar tonal figures, an alternating interplay starts – in the course of which the tritone interval stands out clearly. In bars 9–10 the therapist tries to slow down and somewhat focus the music when she continues the patient's decrescending and retarding melodic form (bars 8–9) in rhythmic augmentation (*sostenuto*). However, the patient interrupts the musical dialogue impulsively and prematurely with a descending tritone motif and again introduces more energy and movement.

BARS 12–15 (SEE FIGURES 10.1 AND 10.2)

With increasing acceleration (*accelerando*, *agitando*), and imitated by the therapist, the patient drives his semiquaver seconds upwards to bar 14, where he takes them down again in thirds and seconds starting with  $c^3$  and lets them fade out slowly. In accordance with the ascending pitch he has also increased the dynamic element, which within a very short time is taken from *f* to *pp* together with the descending melody. Bar 15 indicates a change. The patient concentrates on a singular two-note motif in the form of an ascending second, complemented by a rest, and thus creates a caesura from the previous part. The rest in this context helps him to find his bearings again and to prepare for what is coming.



The musical score is divided into four systems, each with a Piano (P.) and Theremin (Th.) part. The key signature is one flat (B-flat), and the time signature changes from 6/4 to 7/4, then to 3/4, and finally to 8/8.

**System 1 (Bars 13-16):** The Piano part begins with a melodic line in bar 13, marked *mf* *agitato*. The Theremin part provides harmonic support. Bar 14 features a *f* dynamic and a *rit.* marking. Bar 15 has a *pp* dynamic. Bar 16 is marked *p*. A tempo change to *80a tempo* is indicated at the start of bar 16.

**System 2 (Bars 17-20):** The Piano part continues with a melodic line, marked *mf*. The Theremin part provides harmonic support. Bar 17 is marked *mf*. Bar 18 is marked *mf*. Bar 19 is marked *mf*. Bar 20 is marked *mf*.

**System 3 (Bars 21-24):** The Piano part continues with a melodic line, marked *mf*. The Theremin part provides harmonic support. Bar 21 is marked *mf*. Bar 22 is marked *mf*. Bar 23 is marked *mf*. Bar 24 is marked *p*. A *deciso* marking is present above bar 23.

**System 4 (Bars 25-28):** The Piano part continues with a melodic line, marked *mf*. The Theremin part provides harmonic support. Bar 25 is marked *mf*. Bar 26 is marked *mf*. Bar 27 is marked *mf*. Bar 28 is marked *mf*.

Figure 10.2 'Beginning of the 'Farewell Melody': bars 13–28



## BARS 16–23 (SEE FIGURE 10.2)

The patient's new musical idea becomes apparent in a clearer pace (andante) and a continuous quaver pulse – at first well-defined – which the therapist takes up in bar 17 and accompanies with rhythmically alternating triad forms. The quaver metre which appears in the patient's voice for the first time is combined with a tonal figure decending in triads. As soon as the quaver metre rings out in the therapist's voice (bar 17) he gives it up and plays descending tonal passages with frequent syncopes, in transposed rhythm to the therapist. The numerous interruptions (rests) within and between the patient's passages underline the permutating effect of his play. The independent idea in bar 16 has not taken shape in the subsequent bars but remains unconfirmed, non-committal and playful. In bar 23, with its clear tonal reference, the indecision turns into resolution and decisiveness (decisio).

## BARS 24–28 (SEE FIGURE 10.2)

In bar 24, the patient develops a clear, short upbeat theme in a clearly defined 2/4 measure with a regular structure (2+2). He takes up the triads from the accompanying triad motif of bars 17–23, which served to form and generate the metric basis for the therapist. Continuing his play in triads, he not only underlines the harmonic factor but at the same time indicates that he has turned towards a tonal centre (C-major). This decision and the deliberately chosen articulation involved (staccato) introduce a dancing element in his play which resembles a polka.

In summary, the onset of this melodic improvisation of the last session is characterized by the casual, indetermined and open nature of the patient's music. His play gives the impression of something 'temporary'. The short dialogue takes place on this level of expression only, which in part consists of impetuously played tonal figures. The inter-musical relation with the therapist develops accordingly. Musical elements follow each other in quick succession, and the dissonant colouring is also a result of the tritone sound. The patient's seeming sovereignty is supported by his musicality and previous musical experience. He is observant, is able to participate and anticipate musical elements as if he deliberately chooses the musical level he wants to relate to. The patient makes musical decisions and in the interactive play with the therapist dominates the joint music-making.

The following section covers the analytical description of the second example.

*Subsequent course and end of the 'Farewell Melody'*

## BARS 1–15 (SEE FIGURES 10.3 AND 10.4)

Bars 1–15 may be seen as a preparation for the onset of the melody in bar 16. The patient is looking for an appropriate musical expression. The characteristic tonal

figures and thirds described in the first example appear shaped and varied in a similar way in this context. He keeps his play open. His indecision is audible in the glissandi (bars 6, 13), the undefined rhythm and the ascending, ‘questioning’ motifs in dialogue form. Apart from the non-committal glissandi, his music is characterized by ‘randomly’ played short figures (bars 7, 11–13), quickly starting impulses which then fade away and decelerate (bars 1, 3, 15), contrasts between clearly articulated and indecisive notes, and underlined, rather complex tonal figures in consistent form.

The musical score is divided into three systems, each representing a different time signature: 2/4, 5/4, and 9/4. The first system (bars 1-3) features a Patient part starting with a triplet of eighth notes (*mf*), followed by a half note (*allentando*), and then a quarter note (*mp*). The Therapist part has a half note (*mp*) and a quarter note. The second system (bars 4-6) features a Patient part with a quarter note (*Red. ♯*), a half note (*Red. pp*), and a quarter note (*8va*). The Therapist part has a quarter note (*p*) and a half note. The third system (bars 7-9) features a Patient part with a quarter note (*8va*), a half note (*ppp*), and a quarter note (*Red.*). The Therapist part has a quarter note and a half note.

Figure 10.3 Subsequent course: bars 1–12

The musical score is divided into five systems, each with a piano (P) part on a single staff and a tuba (Th) part on a grand staff (treble and bass clefs).

- System 1 (Bars 13-16):** The piano part begins at bar 13 with a half note G4, marked *indeciso*. At bar 14, it changes to a 5/4 time signature and plays a half note G4, marked *gliss. & d.* and *mf*. A *lento* marking is above the staff. The tuba part enters at bar 14 with a half note G2, marked *cal.* and *p*.
- System 2 (Bars 17-20):** The piano part continues with a half note G4, marked *p*. The tuba part has a half note G2, marked *pp*, and a half note G2, marked *p*.
- System 3 (Bars 21-24):** The piano part has a half note G4, marked *mf*. The tuba part has a half note G2, marked *p*.
- System 4 (Bars 25-28):** The piano part has a half note G4, marked *mf*. The tuba part has a half note G2, marked *mp*. A tempo marking  $\bullet = 50$  is above the piano staff.
- System 5 (Bars 29-32):** The piano part has a half note G4, marked *mp*. The tuba part has a half note G2, marked *mp*. A tempo marking  $\bullet = 60$  is above the piano staff.

Figure 10.4 Subsequent course: bars 13–32

The inter-musical relationship with the therapist is apparent in the melodious element, the diastematic aspect, and may be seen in bars 5–10. Here, the patient takes up the ascending movement started by the therapist, complements harmoniously in bar 5, and in bar 7 the appoggiatura chord, and complements the onset of the ascending movement with third sequences, which he gradually takes down step by step. The therapist's clearly underlined transition on the seventh chord in G-major (bar 14), which in its function as dominant seventh chord announces the C-major key, is taken up by the patient in bar 15. The patient's play tells us how he anticipates what comes next. He includes the pedal, the crescendo and ritardando, clearly indicating a new mode of expression, and directs his full attention to the new melodic statement to come. A remarkable effect is the slight delay (after *f*<sup>1</sup>) prior to the onset of his new melodic idea.

#### BARS 16–27 (SEE FIGURE 10.4)

The new element in the patient's voice turns out to be a melodic motif ascending in seconds, which stands out against the previous, mainly descending tonal sequences. He lends significance to this motif since he articulates each single note and presents it in a *lento* character. Another new element is his choice of a harmonic relation (C-major) and a specific metre (4/4). In repeating and expanding the ascending second motif (bars 17–18) he decides on a more comprehensive melodic form, which creates a combination of eight bars in all (bars 16–23). On the basis of this combination he expands his melodic gestalt with variations (bars 24–27), in close adherence to the basic harmony. His rhythmic ideas develop coherently and in accordance with the melodic–harmonic tension. His appoggiatura motif (bars 20–21) assumes the nature of 'sighs', held back in expectation of the harmonies introduced by the therapist for a better effect of the resolution of suspensions and leading notes. The inter-personal relationship becomes more intensive and on the musical level indicates the shared melodic line. This can only be achieved by mutual waiting for each other. The transitions between bars illustrate this fact most effectively, such as in bars 21/22, 23/24, 25/26 and 26/27/28.

#### BARS 28–50 (SEE FIGURES 10.4–10.6)

The quaver triplets appearing in the patient's voice for the first time (bars 25–26) and reflected in the therapist's bass accompaniment lead to a new type of metre (6/8), which introduces a different, flowing, mobile and swinging expression into the melody. The new upbeat start of phrases, as an ascending three-eighth movement with subsequent fading dotted quarter notes, serves as a melodic means of expression for the patient. He lends it importance with dynamic interpretation

The musical score is presented in four systems, each with a piano (P) part on a single staff and a therapist (Th) part on a grand staff (treble and bass clefs).  
 System 1 (bars 33-36): The piano part begins with a melodic line starting on a half note, followed by quarter notes, and a half note. A slur covers bars 33-36. Dynamics include *rit.* and *pp*. The therapist part provides harmonic support with chords and single notes.  
 System 2 (bars 37-40): The piano part continues the melodic line. Dynamics include *mp*.  
 System 3 (bars 41-44): The piano part features a more active melodic line. Dynamics include *f* and *attacca*.  
 System 4 (bars 45-48): The piano part concludes with a melodic phrase. Dynamics include *mf* and *f*.

Figure 10.5 Subsequent course: bars 33–48

and deliberate articulation. In a very subtle manner he forms this continuous melodic phrase comprising eight bars (28–36) and expands it further to fourteen bars (36–50). The most significant general feature is his return to the key note (C-major). A characteristic element in the patient's melody is the distinct opening of the tonal range, which was already suggested in bars 6–8, 23 and 35. It is of specific importance in bars 43–46 with the opening of  $c^1$  to  $g^2$  and corresponds with the therapist's

The musical score is arranged in five systems, each with a piano (P) part on a single staff and a tuba (Th) part on a grand staff (treble and bass clefs).  
- **System 1 (Bars 49-52):** The piano part begins at bar 49 with a melodic line. The tuba part has rests in bars 49 and 50, then enters in bar 51 with a low, sustained accompaniment. Dynamics include *p* (piano) in bars 51 and 52.  
- **System 2 (Bars 53-56):** The piano part continues its melody. The tuba part provides harmonic support with sustained notes and some movement in the bass line.  
- **System 3 (Bars 57-60):** The piano part features a more active, flowing melody. The tuba part has a more pronounced accompaniment. Dynamics include *f* (forte) in bar 58.  
- **System 4 (Bars 61-64):** The piano part continues with a melodic line. The tuba part has a sustained accompaniment with some melodic movement in the bass line.  
- **System 5 (Bars 65-68):** The piano part concludes with a melodic phrase. The tuba part has a sustained accompaniment. Dynamics include *rit.* (ritardando), *ppp* (pianississimo), and *pp* (pianissimo). A tempo marking of  $\text{♩} = 40$  and the word *dolce* (dolce) are present in bar 65.

Figure 10.6 Subsequent course: bars 49–68

accompaniment, who previously, in bars 41 to 43, has opened up the tonal range starting with the bass register (G) to the descant (e<sup>2</sup>) and again passes through from C to c<sup>1</sup> in the bass register. The therapist's sharp dissonance in bar 46 has no discomposing effect whatsoever on the patient in maintaining his melodic lead. The articulated endings of his phrases are remarkable. He continues his melodic line in a highly sovereign manner, in close harmonic contact and comprehensive interpretation.

#### BARS 50–85 (SEE FIGURES 10.6 AND 10.7)

In this section we hear a melodic intensification, clearly formed and developed by the patient, up to a culminating point (bar 59) which turns out to be the climatic note of the whole melodic improvisation. The patient uses his three-quaver note motif to consistently build up the intensification. The gradual preparation for the culminating point itself is achieved in concentrating on the diastemy (ascending pitch, reduction to alternating note motif) and rhythmic shortening (dotted quavers, semi-quavers), which prior to the culminating note create a densification and intensification of movement. Articulation and dynamic interpretation appear in congruence with the described intensifying factors.

This powerful build-up of melodic tension, stringently carried out by the patient (bars 50–59), contrasts with a resolution of this tension descending in two-beat groups, characterized by disintegration of motifs (bars 60–67). The way in which the patient uses, specifies and combines the musical elements for his purpose makes the building up and resolution of tension appear almost deliberately composed.

The resolution of tension in the patient's voice is expressed in the syncopated descending melody (bar 60), which appears indecisive as it continues (bar 62). In compensation, the therapist takes the musical lead from bar 62 to 66 and thus enables the patient to change over to the accompanying voice and then to concentrate on a clear conduct in accordance with the melodic line. It is interesting to see how in taking up a second voice he is again active and to some degree dominant, as he retards the end of the phrase, or allows the therapist to take the lead again with a different expression (bar 67). A remarkable feature of his play is that he does not pass over to the final note which offers itself, c<sup>1</sup> (tonic), but keeps the end open; he pauses and thus leaves the last note to the therapist (who also leaves the final turn open with g<sup>1</sup>).

### Interpretation of the final turn

The patient's new expressivity may be seen as a coda, or a comprehensive final turn of the melodic improvisation (see Figure 10.7). The patient initiates this part very

The musical score consists of four systems, each with a piano (P) staff and a theremin (Th) staff. The first system covers measures 69-72, the second 73-76, the third 77-81, and the fourth 82-85. The piano part features a melodic line with various note values and rests, while the theremin part provides harmonic support with chords and single notes. Dynamic markings include 'p' (piano), 'mp' (mezzo-piano), and 'ppp' (pianissimo). A tempo change to 'allarg.' (ritardando) is indicated in the second system. The score concludes with a double bar line in the final system.

Figure 10.7 Leading to final turn bars 69–85

softly (ppp) on the fifth  $g^1$ ; i.e. as openly as he ended the previous section. The following features are characteristic for this part:

- maintaining the swaying rhythm of the melody
- going back to the harmoniously related, ascending and descending three-tone motifs as connecting passages



- playing transition figures calmly and at length (bars 69/70; 88/90)
- generally broader interpretation of tonal figures (*allargando*)
- reduced pace in a *largo* style, combined with pertinent agogics.

Melody rhythm and dynamic interpretation in combination with agogics form the reminiscence of the previous structure – or architecture – of the whole melodic improvisation. From a psychological perspective, the final part may be seen as a swinging or fading out of the strongly articulated melodic intensification experienced in the joint play before. An important element is the 'conclusion' of a commonly experienced, exciting melodic improvisation with a close inter-personal relationship, which became apparent in a densely structured exchange of melodic motifs and an overlapping harmonic fabric of voices.

After this improvisation the patient commented on his music-making. For him, it was in accordance with the mood of that day, which was that of a farewell. 'The farewell idea comes out in the music', he said; which was his way of saying that from a 'protected and safe' environment where he was confronted with his inner self and with therapeutic challenges, he was released again into independence and responsibility, which in general is a greater challenge for him due to the decision-making involved and the resulting drop in self-esteem.

### **On the significance of the melody**

Reflecting upon the significance of this 'Farewell Melody' for the patient, two facts appear.

- His impaired hearing did not appear to affect him during the melodic improvisation, nor in the other music therapy sessions. This fact alone is recognizable in his skills of dynamic interpretation and his differentiated perception. It is possible that the more outstanding impulsive tonal figures and the forte played out deliberately indicate hearing impairment; for the therapist, however, it is more likely that they reflect his current situation and personal qualities.
- It is obvious that his previous musical experience enters into the melodic improvisation. This is evident in the pleasure he takes in playing, and his open and explorative expression. However, the start of the melodic improvisation (Figures 10.1 and 10.2) also illustrates his limitations, which appear in the musical relation as part of the interpersonal relationship. In the course of the melody development (Figures 10.3–10.5) these limitations decrease. The patient is able to act and

interpret freely in the context of the inter-personal relationship, the musical expression of which may be seen in the close harmonic–melodic relation.

This melodic improvisation conveys the impression of a patient who uses the opportunity to be creative and to establish closer contact in creative music-making, which he does in a very convincing manner. The nuances of his expressivity range from soft, subtle notes to fully played-out, energetically exploding sounds. His need for expressive expansion, or finding his inner self, may be demonstrated on a musical level in the increasingly differentiated expressivity of his play and the developing melodic lines.

With regard to the difficulties to reach decisions mentioned by the patient (for himself and also in relation with someone else), this melodic improvisation has demonstrated that the patient is able to decide. He is not timid about it but accepts the challenge and tries to find a musical expression.

At first (Figures 10.1 and 10.2), he expressed these decision-making processes in a very vague and superficial manner; but with each new step in this process he gradually found a new expressivity and a better approach to his inner self. The indeterminate character of his musical expression, which dominated at the beginning of the 'Farewell Melody', was gradually lost in the course of his melody and replaced by a more determined, straighter and clearer mode of expression. This process of finding himself finally led him to a deliberate, expressive melodic intensification. In relation to the therapist he chooses this intensification which he builds up successively. For this purpose he uses the personal experience gained in interactive music-making, and in the subsequent relaxation phase follows his emotions and expresses them in a subtle and gentle style. He anticipates the jointly played final turn with confidence. This positive experience of his inner self that becomes apparent in his independent, autonomous musical performance in the context of the therapeutic relationship might help him to build up renewed self-confidence in his everyday life, to trust his own resources and to develop a more optimistic view of the future. He will possibly be able to show more courage in coping with his personal situation and to employ his potential whenever deliberate, purposeful and responsible action is required.

If we consider that music-making in therapy transforms personal deficits, we gain a new insight in this case; the patient's initiative to take decisions, in combination with his newly awakened ability to develop comprehensive melodic phrases, is an indication that he is able to relate on a cognitive and emotional level with what he does. This congruence of perception, feeling and action might help him to recover the internal balance he has missed so much for some time.

As we have seen, the aspect of separation is significant in depression with regard to an insufficiently effected separation between self and object. His melodic improvisation, as a 'Farewell Melody', emphasizes the significance of the last session, and also underlines the aspects of 'differentiation' and 'separation' within the emotional interplay between patient and therapist, and the patient's melodic voice that emerges from the interplay. The 'Farewell Melody' has thus contributed to a successful process of detachment, which has encouraged the patient's independence in supporting his musical autonomy. His performed identity, as an independent melody, appears within a relationship.

## On Listening

As in the first study, the four music therapy sessions with the 'Farewell Melody' were presented and listened to at a single stretch, for a first review and general impression of the therapy. An index covering the audio tapes of the four sessions was set up.

In all four sessions, only one instrument was used, and several improvisations on this instrument developed in the therapy course. In the first session, the therapist suggested the instrument, whereas in subsequent sessions the patient himself chose the instruments for his musical improvisations.

The patient's musicality and previous musical experience were clearly audible in all sessions and apparent in his delight and intention to present a variety of modes. Improvisations created during sessions depended on the patient when he had employed his freely chosen style in such a way that a final turn in his musical activity followed naturally. The 'exploitation' of his personal musical ideas demonstrated not only his musical creativity but also his limitations, which became apparent in the musical relationship as part of the interpersonal relation.

We must remember in this context that it is not the individual therapy sessions that are under consideration but the selected episodes that emerged from the analytical cycle of listening as being important contributions to the development of melody. These episodes provide the data material for our second study.

### Selecting episodes

All four sessions were played and listened to repeatedly, in accordance with the cycle of naturalistic inquiry. This first cycle of listening led to a second one in which significant sessions were selected with important data material on musical-melodic elements.

A result of this second cycle was a focus on therapy sessions 1 to 3. In contrast to the first study with a selection of two sessions, all three therapy sessions in this second study provided relevant material for a focused analysis. In a further listening cycle, episodes were selected from these three sessions as basic material for analysis and interpretation. The sequence of the analytical listening cycle rendered a total of 16 episodes.

## Validation of episodes with the personal construct theory

In Figure 11.1 we see the focus grid of the constructs as they relate to the episodes after elicitation using the triadic method of comparison. A total of 13 constructs emerge and these are then bundled together as five overarching, or superordinate, construct categories (see Figure 11.2).

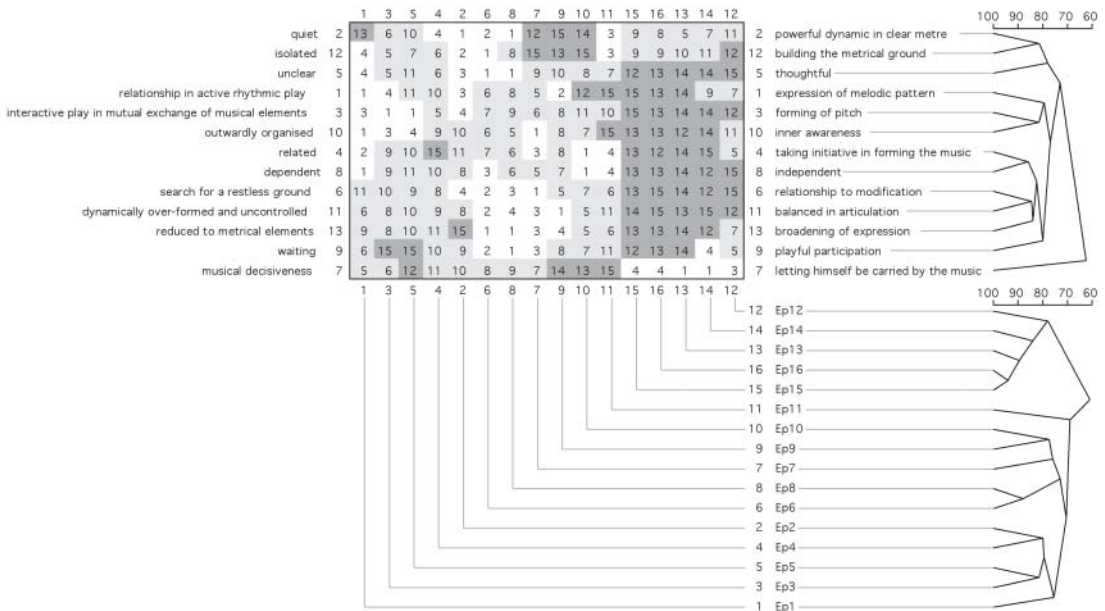


Figure 11.1 Focus grid of constructs elicited from the episodes

## Categories of episodes

The focus analysis of grid elements shows how the episodes are also clustered together. In Figure 11.3, we can see clusters of five and four episodes, as well as single outstanding episodes. These constitute the specific clusters of episodes that

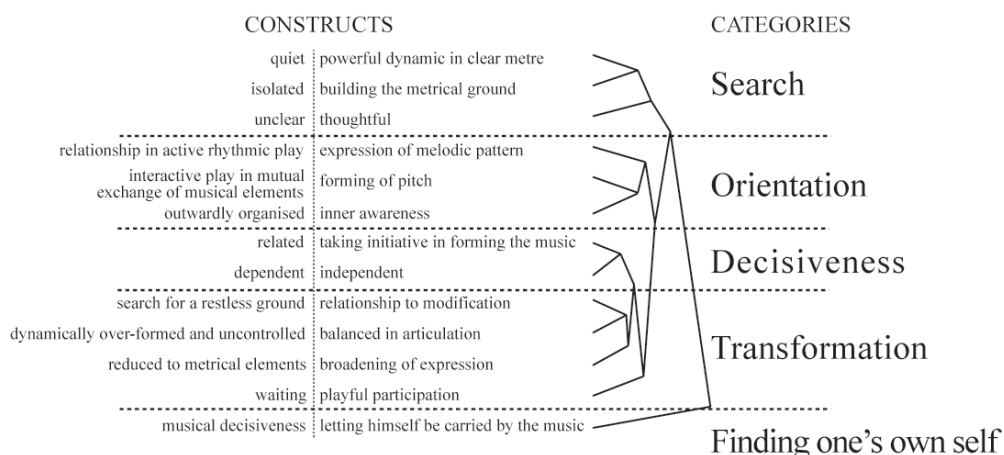


Figure 11.2 Generating categories from constructs

emerged from the therapy course from the first, second and third sessions. This process led to a reduction in data and helps us to a focus on particular episodes. The definitions of these categories based upon episodes evolve empirically from the experience of the therapist and demonstrate the course of therapy as it unfolds over time, with five periods that are significant for the structure and development of the melody. We see graphically in Figure 11.3 the categories of the episodes as they unfold over the course of the therapy.

## Significance of construct categories

### *Orientation (Orientierung)*

From the nineteenth century, the German noun *Orientierung* – derived from the verb form – has been associated with the meaning ‘knowledge of direction and territory; mental attitude and direction’. In the second half of the eighteenth century, the verb *orientieren* meant ‘to align something with the rising of the sun, in accordance with the points of the compass, as in orient, to the east’. In the nineteenth century, it was associated with the French verb *orienter* and used in the same sense; that is, to ‘determine the position, align, adjust, inform, find one’s way, gain an overview’ (Drosdowski, 1989; Pfeifer, 1997).

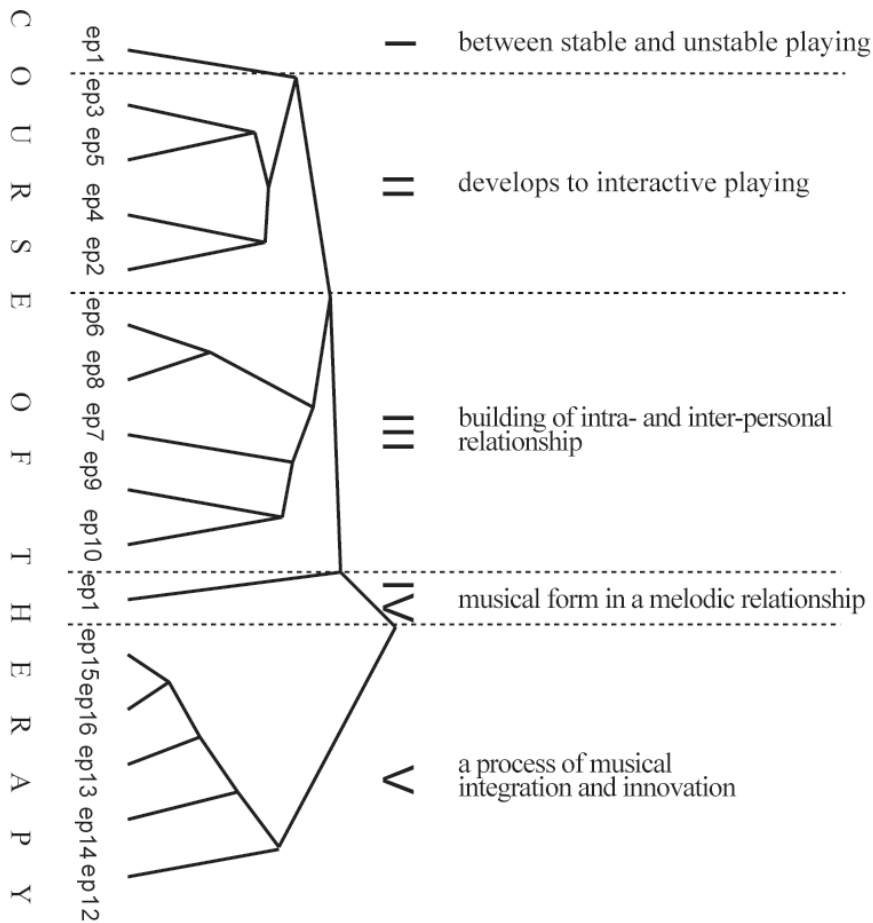


Figure 11.3 Categories of episodes as they relate to the course of the therapy

In the context of the second study this category has this semantic meaning. The patient tries to find his way, to align and adjust himself to something (music) and somebody (therapist).

However, this is not possible without an opening of the senses, nor without 'becoming aware' of the internal and external world, so that anticipation is also significant here.

### *Search (Suchen)*

The verb *suchen* (English 'search') has the meaning of 'pursue searchingly, inquire, investigate, research, with the intensive wish to find' (Pfeifer 1997). It is related to the Latin *sagire*, which means 'scent, sense, have a presentiment of'. From the times

of Old High German, *suchen* has been used not only in the meaning of 'make an effort to find something hidden or lost' but also in the meaning of 'strive for something, make an effort to achieve something'.

The meaning of this category for this study is similar. The patient is searching for something new, or hidden, and tries to find 'something' to play with. This category also comprises the expression of insecurity, inconsistency, indecision, and aimlessness, and also an attitude of waiting as a sign that the patient is not yet ready.

### *Decisiveness*

In the early stages of Modern High German decisiveness acquires the meaning of 'decide, arrive at a decision, bring oneself to tackle a certain task' (Drosdowski 1989; Pfeifer 1997). With regard to this study, this category means that the patient has recourse to his determination in order to arrive at a resolution and decision. He has access to his will-power. In his activity and initiative he shows his efforts to reach a decision, although the objective of the decision seems still unclear and in part is concealed by his energy. Moreover, this energy is a source of his need for emotional expression, which he cannot control and bring into shape at this time.

### *Transformation*

The verb belonging to this noun has the meaning of 'change, modify, turn, alter' and is derived from the Latin *transformare*. Accordingly, the meaning of the noun is 'change, modification, turn, alteration'. Considering the prefix 'trans...', 'Trans...' by itself, we get the meaning of 'through, forth, beyond' (Drosdowski 1989; Pfeifer 1997).

This category suggests that the patient is able to change, alter and modify the musical material, to reshape and transform it. This may be seen in the musical parameters and musical principles. The patient is able to reshape, and thereby change, the musical material; at the same time he expands his creative and interpretative repertoire and lends a personal style to the transformation. The way in which he carries out this transformation also illustrates his inner emotional condition in a peculiar manner. Therefore, the category also indicates the chance to perceive a transformation of the inner self; internally, he passes through something; the patient allows himself to be transformed and changed.

### *Finding one's self*

This category contains the common Germanic pronoun *selp* for which there is no definite etymological explanation. The usual form of the pronoun is *selbst*, identical



with the noun *Selbst*, with the meaning of ‘the ego aware of itself’ (Drosdowski 1989).

Here, the patient is able to create confidence within himself; he can build up self-assurance, develop optimism, rely on his feelings, feel increasing security in the music therapy situation and find personal expression. This means he has achieved personal integration and also inner synchronization. With his potential and skills he is increasingly able to free himself from ‘ingrained modes of play’, to determine his expression and to create room for his expressivity. This might help him to experience himself immediately as an ego in time; that is, to hear and experience how his innermost self emerges in a very dynamic and lively way in his own musical expression.

A further important experience in self-discovery is the relation to another person. The chance to reflect oneself in somebody else may – on a musical level – lead to changes that enable him to find more flexible patterns of reaction and expression. A therapist’s interventions may encourage a patient’s flexibility with regard to interactive, synchronous music-making in dialogue form. This active component of self-discovery in improvisation indicates the possibility of interpreting the self as ‘new’ without the limitations of a particular perspective (Aldridge 1996a, p.22).

## Summary

The categories of constructs and episodes (Figures 11.2 and 11.3), gleaned through personal construct theory, provide the focus in our analysis of the data. The grid analysis graphs illustrate that the episodes do not occur in isolation to each other but are interconnected in a specific way. What connects them is defined by the contents of the constructs. We may discern an example of a ‘connecting pattern’ in the cluster of the four episodes 2–5, as an example of the category ‘development of interactive play’. The question in this context is how the patterns of interaction developed in Episodes 2–5 relate to the categories of constructs; i.e. to orientation, search, determination and self-discovery.

A study of these aspects brings us to the subsequent Chapter 12 where a detailed analysis of the second study is described.

## Analysing the ‘Farewell Melody’

In the melody analysis of this study we use a variety of graphic signs, like directional arrows and parentheses, within the musical examples to demonstrate musical interactions and relations between patient and therapist. The legend of graphical signs is similar to that of the first study, with some modifications (see Table 12.1).

**Table 12.1** Graphical signs used in the analysis of the ‘Farewell Melody’.









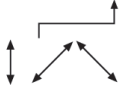

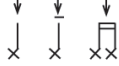
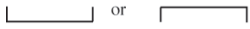
	Rhythmic voice of the patient on the conga drum; high sound, edge of the drumhead (Episodes 1–5)
	Rhythmic voice of the patient on the conga drum; high sound, edge of the drumhead (Episodes 1–5)
	Rhythmic voice of the patient on the tom-tom; parallel play (Episodes 6–11)
	Rhythmic voice of the patient on the temple blocks; higher notes (Episodes 12–16)
	Rhythmic voice of the patient on the temple blocks; deeper notes (Episodes 12–16)
 or 	Inter-musical voice of the patient on the temple blocks; deeper notes (Episodes 12–16)

Table 12.1 continued

	Musical references between patient and therapist, originating from one side
	Musical references between patient and therapist, originating from both sides
	Marking certain notes with accentuation or special rhythmic effects
	Accentuation of expressive musical features
	Marking related parts, like motifs, groups of motifs, and melodic figures

## Unstable play (Episode 1)

The first episode is part of the first improvisation in the first session. The patient plays the conga drum accompanied by the therapist on the piano (see Figure 12.1). With the beginning of this episode, the patient demonstrates, for the first time, a clarity in his musical expression that makes his relation to the music audible. The categories orientation and search begin to appear in the following episodes.

### ORIENTATION

The therapist's evenly sustained quaver time in an alternating bass descant (treble) accompaniment and staccato articulation helps the patient to find more clarity in his play, which he brings into relation with the 4/4 time. The tonal substance of the accompanying chords consists of dissonant sounds (second–seventh) of the whole-tone range. In combination with a naturally emerging accent (on one and three) they form half-phrases.

The patient performs the last key crotchet as a rhythmic pattern with a crescendo and thus creates an upbeat effect aimed at the first part of the following bar which he accentuates. A remarkable feature is his stressed, articulated semiquaver notes (see Figure 12.2).

Subsequently, his struggle for orientation is revealed in the denser rhythmic movement, whereby the first part of the bar always becomes audible as a key crotchet beat (see Figure 12.3). Here again, he consistently sustains his crescendo and changes over to the darker timbre of the centre of the drumhead.

These musical figures – clearly expressed for the first time – are in contrast with the unclear rhythmic patterns of the following dialogue section (bars 7–10).

The musical score is divided into three systems, each containing a Patient (Conga) part and a Therapist (Piano) part. The key signature is one sharp (F#) and the time signature is 4/4.

- System 1 (Measures 1-3):**
  - Patient (Conga):** Measures 1 and 2 feature a rhythmic pattern of eighth notes with accents. Measure 3 has a single eighth note with an accent. Dynamics range from *mp* to *f*.
  - Therapist (Piano):** Measures 1 and 2 feature a melodic line in the right hand and a bass line in the left hand. Measure 3 has a single eighth note in the right hand. The instruction *sempre stacc.* is written below the staff.
- System 2 (Measures 4-6):**
  - Patient (Conga):** Measures 4 and 5 feature a rhythmic pattern of eighth notes with accents. Measure 6 has a single eighth note with an accent. Dynamics range from *p* to *f*.
  - Therapist (Piano):** Measures 4 and 5 feature a melodic line in the right hand and a bass line in the left hand. Measure 6 has a single eighth note in the right hand.
- System 3 (Measures 7-10):**
  - Patient (Conga):** Measures 7 and 8 feature a rhythmic pattern of eighth notes with accents. Measures 9 and 10 have a single eighth note with an accent. Dynamics range from *p* to *f*.
  - Therapist (Piano):** Measures 7 and 8 feature a melodic line in the right hand and a bass line in the left hand. Measures 9 and 10 have a single eighth note in the right hand.

Figure 12.1 Episode 1

#### SEARCH

Bars 9 and 10 provide an example of the search category (see Figure 12.4). The patient seems to strive for a rhythmic form that he is still unable to place into a meaningful context. His repeated accents prevent any clear form and his play appears rather desultory. An interesting fact is that the patient maintains musical contact with the therapist via the third key crotchet beat, which he times precisely with the



Figure 12.2 Episode 1: bars 1–2



Figure 12.3 Episode 1: bars 5–6

therapist. As to timbre, he still prefers the darker centre of the drumhead (see note heads below the line with downward stems).

Later, in bars 11 and 12, we find another example of the search category (see Figure 12.5). The patient enters into an even quaver metre, thus accepting the therapist's metric play, which provides a safe 'foundation'. At the same time he changes over to a higher timbre on the edge of the drumhead.



Figure 12.4 Episode 1: bars 9–10



Figure 12.5 Episode 1: bars 11–12

The first thing to attract notice is the patient's enthusiasm. He stresses the different timbres from deep to high notes with considerable technical skill. He loves to be active and reveals a strong intention to perform rhythms. As soon as he finds access to a form of beat, which he can share with the therapist, he strives for orientation. There is a conspicuous contrast between distinct and indistinct play. In the distinct sections, the patient employs dynamics, articulation, timbre and rhythmic patterns to create musical forms that fade to some extent in the unstable part.

In the clearly expressed phase, the patient has the tendency to take the lead and further pursues this in crescendo with semiquaver phrases starting from bar 4. In bar 7, he even ventures to initiate an alternate play with the therapist, but then he loses clarity. We might assume that the dialogue form he initiated, revealing a relationship between patient and therapist, has been chosen too early in this context and that he therefore withdraws into unclear, desultory playing.

## **Development towards interactive play (Episodes 2, 3, 4 and 5)**

### *Development towards interactive play: Episode 2*

The second episode shows the start of the second improvisation from the first session (see Figure 12.6). The patient begins to play in a quiet pace. This episode also involves the categories of search and orientation; however, here they appear in the context of 'development towards interactive play' and thereby already indicate a process with a potential for development and growth.

#### SEARCH

The musical example of this category emerges in the first three bars. Starting with a tentative, cautious and unclear utterance, the patient looks for a musical form. Despite his almost inaudible play in ppp, he starts to accentuate in the very first bar. The pattern of this bar, which resembles a syncope, appears as a retrograde motion in bar two (see Figure 12.7). In the third bar, his search takes the shape of a pattern that may already be associated with a measure (2/4).

The therapist, very quietly (ppp), takes up tonal contact with the patient with the minor f.

Over the following bars, the patient sustains his syncopated pattern with an accent on the crotchet note. From bars 7 to 11 he combines the two rhythmic motifs from bars 2 and 3, which in their consistently sustained constellation form two-measure units.

In addition, the therapist gradually expands her tonal range in relation with the patient; her whole notes (from bar 7 half-notes) serve as a tonal blend of the patient's rhythmic figures. The octave H/minor h with the notes f – g sharp and d define the tonal range and take up the patient's quiet play.

#### ORIENTATION

Two examples may be quoted as belonging into this category. The first concerns bars 11–13, the second bars 16–18 (see Figures 12.8 and 12.9)

The musical score is divided into six systems, each featuring a Patient (Conga) part and a Therapist (Piano) part. The Patient part is written on a single staff with 'x' marks for notes, and the Therapist part is written on a grand staff (treble and bass clefs).

- System 1:** Patient (Conga) starts with a *ppp* dynamic, followed by a *pp* dynamic. The Therapist (Piano) part begins with a *ppp* dynamic.
- System 2:** The Patient (Conga) part continues with a *mp* dynamic. The Therapist (Piano) part continues with a *mp* dynamic.
- System 3:** The Patient (Conga) part continues with a *mp* dynamic. The Therapist (Piano) part continues with a *mp* dynamic.
- System 4:** The Patient (Conga) part continues with a *mp* dynamic. The Therapist (Piano) part continues with a *mp* dynamic.
- System 5:** The Patient (Conga) part continues with a *mp* dynamic. The Therapist (Piano) part continues with a *mp* dynamic.
- System 6:** The Patient (Conga) part continues with a *mp* dynamic. The Therapist (Piano) part continues with a *mp* dynamic.

The score includes various musical notations such as rests, notes, and dynamics (*ppp*, *mp*). The Patient (Conga) part is marked with 'x' for notes, and the Therapist (Piano) part is marked with 'P' for notes. The score is divided into measures by vertical bar lines.

*Figure 12.6 Episode 2*



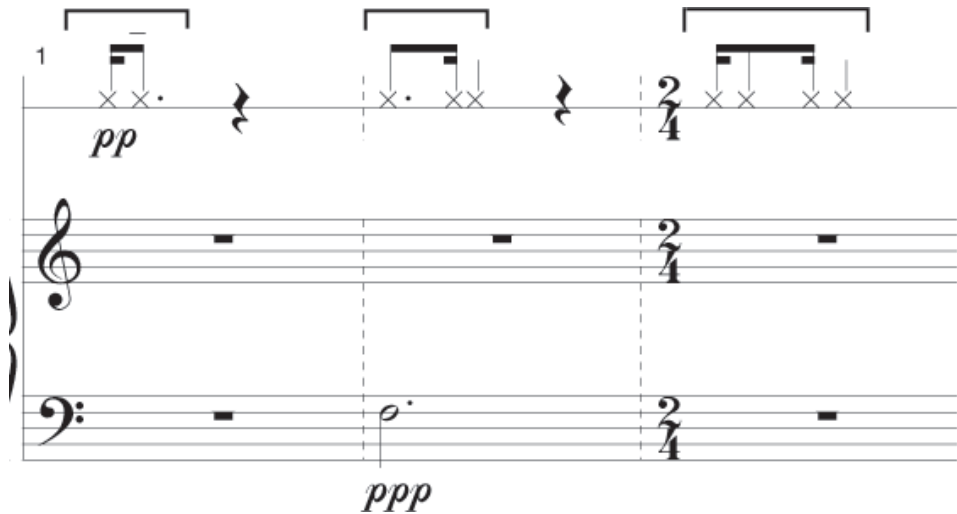


Figure 12.7 Episode 2: bars 1–3

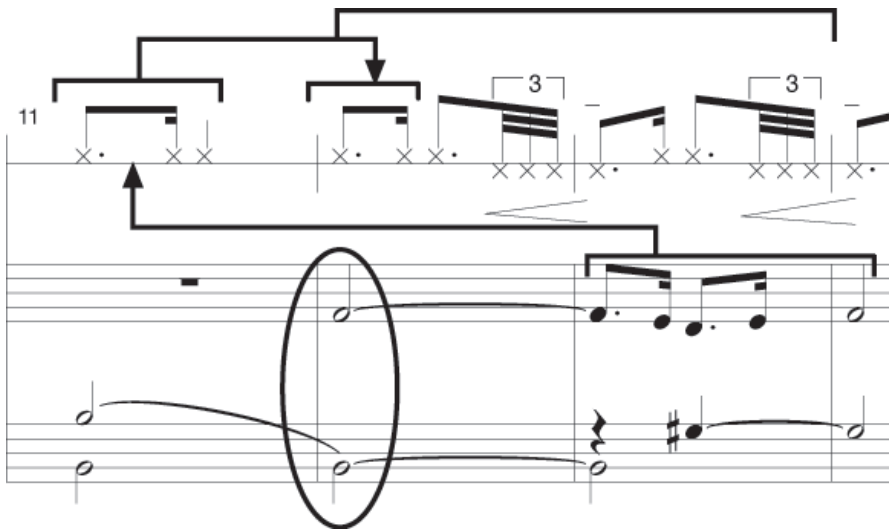


Figure 12.8 Episode 2: bars 11–13

The patient starts to orientate himself tonally starting in bar 12. This orientation, which is directed towards the centre of the drumhead and therefore towards deep timbre, condenses the playing with a finger roll as a demisemiquaver triplet with an upbeat towards the following bar. He gives dynamic expression to the finger roll (crescendo) and in doing so leaves the synopated pattern of bar 3. The metric key

vibration of the 2/4 metre consists here in the dotted motif of bar 2, and the second crotchet appears as a triplet variant. With the exception of bars 16 and 17, the patient sustains this mode up to the end of the episode.

Apart from the octave B, the therapist implies, for the first time, a two-voice texture starting with bar 12, which employs the dissonant twelfth chord as a tonal context (B/f<sup>♯</sup>). Also for the first time she introduces a melodic second motif that changes the patient's rhythmic motif from bar 11 into a melodic one. The tritonic tension and the quiet dynamics contribute to the characteristic expression of this episode.

The second example of the orientation category refers more to the therapist's voice that prolongs the melodic motif here in rising upward from minor h to f<sup>♯</sup> and creating an expectant tension with the tritone. The therapist takes up the accented first part of the beat and integrates it into her melodic contour as a rhythmic element. With this melodic figure the therapist gives the patient orientation for continuity of melodic forms. It may be assumed that this helps him to sustain his mode of play over several bars.

Both patient and therapist unconsciously anticipate many musical elements in this episode. The therapist, for example, anticipates a new rhythmic unit with the changes in the patient's voice in bar 16 (rhythmic abbreviation, tonal reinforcement of crotchet notes) and responds with a more distinct tonal accentuation (see Figure 12.9). Another example may be found in bar 11. The therapist interprets the 'altered' two repetitions of the dotted motif as a sign of something new, which actually happens in bar 12, and responds with a melodic motif (see Figure 12.8). The patient anticipates the accentuated parts of the bar and finally gains confidence. It is

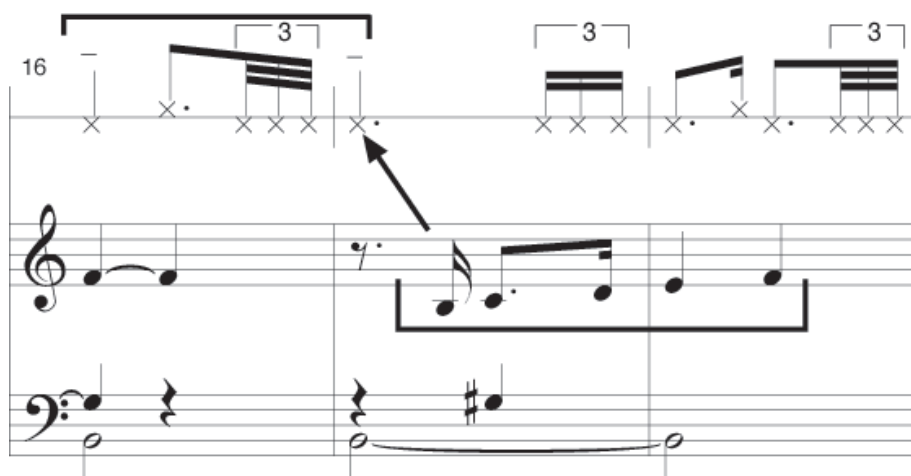


Figure 12.9 Episode 2: bars 16–18

also possible that he anticipates the development of the melodic motif, because in bar 18 he is drawn back to the same mode.

Figure 12.10 illustrates the development of the two categories search and orientation on the basis of a rhythmic motif, in itself an evolving dynamic pattern.

Episode 2 reveals that the patient is able to build up his music successively out of the two first patterns, which emerge in a still vague and unclear manner. With the help of his developing rhythmic motif, he is able to find musical connections (half-phrases) and orientation, not only in his own rhythmic voice, but also in the timbre of his instrument and the therapist's changing measures and her melodic motifs. Both the categories of search and orientation already suggest inter-musical connections. Patient and therapist approach each other within a subtle tonal range. The therapist's corresponding comment in her personal remarks is, 'A tentative sense of a relationship is becoming a possibility.'

Compared to Episode 1, the patient's play again shows a tendency to condense. What the therapist perceives is a hidden restlessness in the patient revealed in his rhythmically denser mode of play. This seems to help him to gain the distance he needs in order to perceive the relation with the therapist. In the foreground is the tentative rhythmic search at a slow pace, the quiet playing (ppp), timbre and articulation.

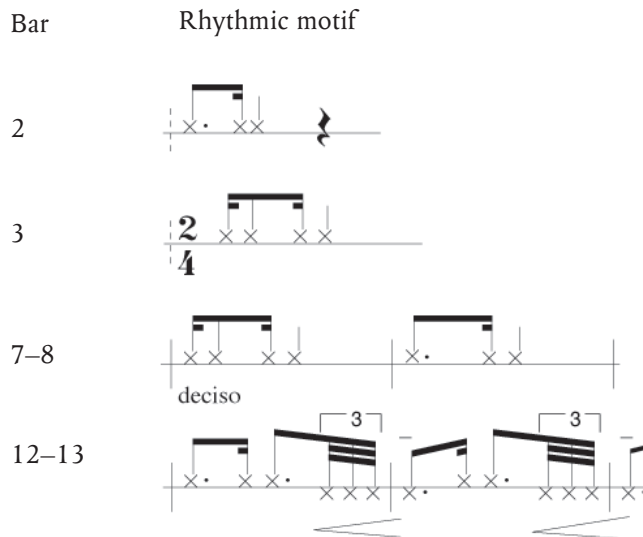


Figure 12.10 Development of a rhythmic motif through bars 2 to 13

His rhythmic patterns have a similar structure: upbeat, crescendo and accented, combined with a driving, forceful character which creates a certain restlessness and agitation.

### *Development towards interactive play: Episode 3*

Episode 3 is part of the second improvisation of the first session and evolves from Episode 2. It is shown in Figure 12.11.

The musical score for Episode 3 is divided into four systems, each featuring a Patient (Conga) part and a Therapist (Piano) part.

- System 1:** The Patient (Conga) part starts with a 6/8 time signature and a *p* (piano) dynamic. The Therapist (Piano) part is in 6/8 time, with a *p* dynamic in the right hand and a *f* (forte) dynamic in the left hand.
- System 2:** The Patient (Conga) part continues with a *p* dynamic. The Therapist (Piano) part features a *ff* (fortissimo) dynamic in the right hand and a *f* dynamic in the left hand.
- System 3:** The Patient (Conga) part continues with a *p* dynamic. The Therapist (Piano) part features a *p* dynamic in the right hand and a *f* dynamic in the left hand.
- System 4:** The Patient (Conga) part continues with a *p* dynamic. The Therapist (Piano) part features a *p* dynamic in the right hand and a *f* dynamic in the left hand.

The score includes various musical notations such as rests, notes, and dynamic markings (*p*, *f*, *ff*, *leggiere*, *sempre stacc.*).

Figure 12.11 Episode 3

*continued on next page*

The musical score is divided into four systems, each featuring a piano (P.) part and a theremin (Th.) part. The systems are numbered 16, 20, 24, and 28.

- System 16:** The piano part consists of a series of eighth notes. The theremin part features a melodic line with eighth notes and rests, marked with *8va* (octave up).
- System 20:** The piano part begins with a *p* (piano) dynamic and a *giocoso* (playful) tempo marking. The theremin part continues with a melodic line, marked with *8va* and *8va* (octave up).
- System 24:** The piano part includes a *decresc.* (decrescendo) marking. The theremin part features a melodic line with eighth notes and rests, marked with *8va* and *8va* (octave up).
- System 28:** The piano part includes a *p* (piano) dynamic and a *rit.* (ritardando) marking. The theremin part features a melodic line with eighth notes and rests, marked with *p* and *rit.* (piano and ritardando).

Figure 12.11 Episode 3 continued

continued on next page

The musical score consists of three systems, each with a Percussion (P.) and Theremin (Th.) part. The first system (bars 32-35) shows a rhythmic pattern of 'x' marks on the P. staff and a melodic line on the Th. staff. The second system (bars 36-39) continues the pattern, with an 'accel.' marking on the Th. staff in bar 37. The third system (bars 40-43) shows a continuation of the melodic line on the Th. staff, ending with a fermata in bar 43.

Figure 12.11 Episode 3 continued

The categories of orientation and determination emerge more clearly in this episode; the search category appears only at the beginning.

#### SEARCH

The musical example of this category is contained in bars 2–3 (see Figure 12.12). The patient is looking for a mode of play that does not involve him in the therapist's dynamic intensification. In contrast to her opening of the tonal range, distinctly perceivable in octaves with an even metre and gradually growing dynamics, he resolves his rhythmic play in soft intonation and switches over to the freer tremolo mode. In this context, search appears in the expression of reserve (p). The tremolo allows him

to maintain a hesitating attitude so that he does not have to decide on a clear mode of expression.



Figure 12.12 Episode 3: bars 2–3

#### ORIENTATION

Several musical examples point towards this category, the first is bar 7 (see Figure 12.13). In bar 6, the patient starts afresh with the tremolo and changes over to a crescendoing and decrescendoing wave movement; in bar 7, he follows the tonal effects of the instrument and gradually includes the lighter sound at the edge of the drumhead. The tonal contrast between centre and edge of the drumhead creates an analogous spatial effect of far (edge) and near (centre).

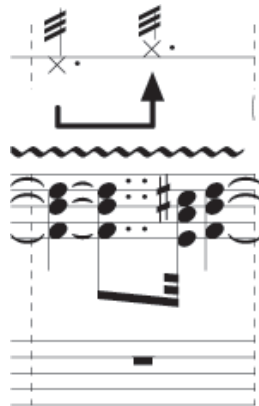


Figure 12.13 Episode 3: bar 7

The patient's tremolo movement is supported by a trill on a<sup>2</sup> (with the upper second b<sup>2</sup>) which the therapist underlays with sharply dotted diminished major triads and lines up in seconds. Due to this trill, a flexible metre evolves leading to different lengths of bars and from bar 10 onwards going over to 2/4 time.

Another example of orientation may be discovered in bars 10–13 (see Figure 12.14). The patient orientates himself following the therapist's musical voice. He anticipates the end of the tremolo part, which is already announced in bar 10 in the distinct 2/4 time and is clearly underlined and accentuated by the therapist in bar 11 with the threefold repetition of the seventh chord in B-flat major. It is conspicuous here that his orientation produces a meaningful and musically logical mode of play. In bar 10 he guides the lighter sound (far) back to the centre (near) and in bar 11 concludes the previous section with a clear quaver downbeat (cut-off) on the first beat, precisely in tune with the therapist on the first beat. From then on he takes the metric lead in a very light, almost relaxed touch and soft dynamics.

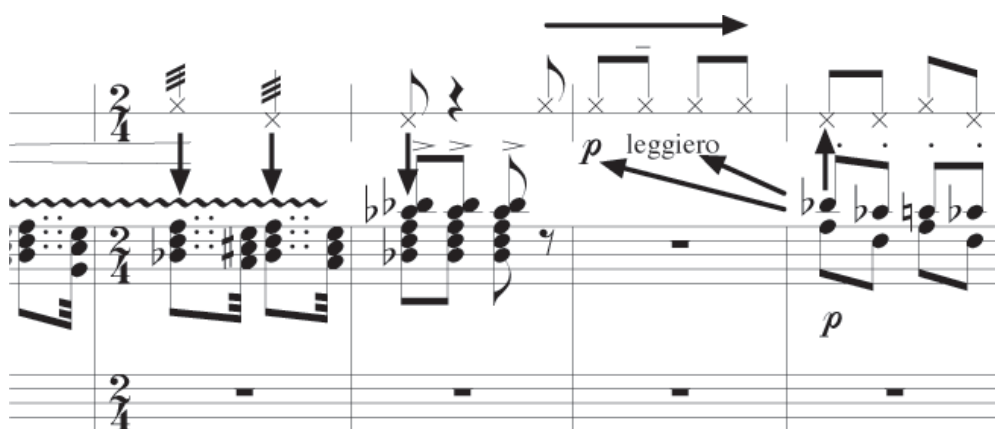


Figure 12.14 Episode 3: bars 10–13

Somewhat later (bars 19–20), the patient combines sound and rhythm and changes over to an almost exuberant play (see Figure 12.15). The previous rhythmic motif of quaver and two semiquaver notes sustained over several bars is now varied, with more strongly dotted subdivisions that produce a galloping effect.

The therapist takes up this expression in two-tone chords with fourths, thirds, tritones and sixths, whereby seconds and thirds alternate in the uppermost voice. This light and apparently effortless touch is further underlined by the articulation





Figure 12.15 Episode 3: bars 19–20

(sempre staccato), the high pitch and soft dynamics. The repetition of two-tone chords goes over to units of half-phrases.

A last example of orientation appears at the end of this episode after the determination category. In bars 37–39, the patient again finds orientation in the therapist's voice, which introduces a fresh element with the downward scale (see Figure 12.16). After an immediate rhythmic response to this intervention he takes up the therapist's scale movement and pursues it in even semiquaver sequences in synchronized play.



Figure 12.16 Episode 3: bars 37–39

## DETERMINATION

The first example of determination emerges in bars 25–27. The patient takes the initiative for a dialogue; he leaves room and reduces his own play to an appoggiatura motif, alternating between high and low timbre, with an accent on the deep sound (see Figure 12.17). In bar 27, the therapist falls in with the dialogue with contrasting accentuation. The contrary effect may be perceived not only in accentuation but also in the single, outstanding octave chords, in the tonal range as well.

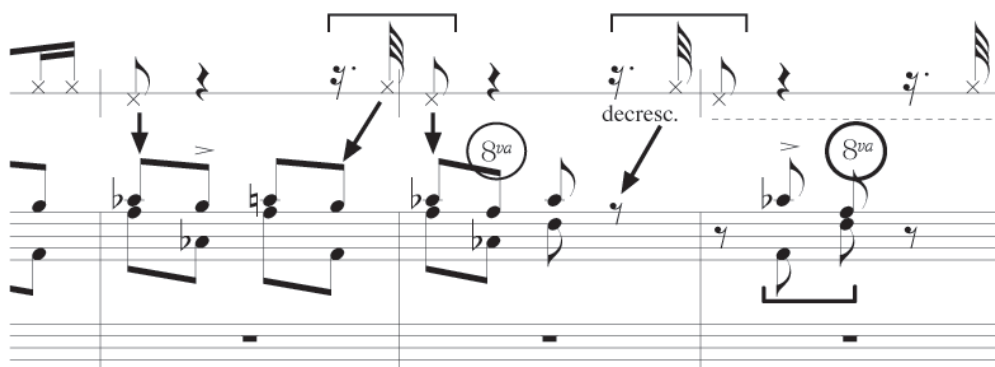


Figure 12.17 Episode 3: bars 25–27

The end of this part provides the second example of determination, which is again initiated by the patient, announced musically by the decrescendo starting as early as in bar 26, continued until bar 30 and connected with a ritardando (see Figure 12.18).

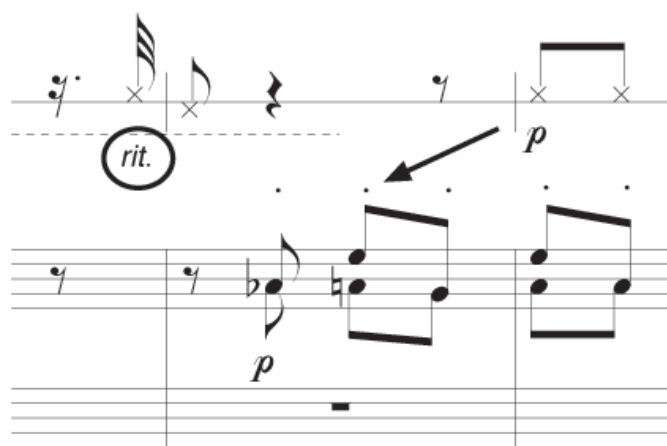


Figure 12.18 Episode 3: bars 30–31

We hear an interactive mode of play evolving from the intervention of a strong musical intensification at the beginning of this episode. The patient creates his own dynamic gradation, diverging from the therapist, which he has to play out with an emphasis on dynamics. Bars 10 and 11 constitute a turning-point (Figure 12.14). The patient follows the therapist's play, anticipates the final chords of the previous section and dominates the further course. He develops his own musical forms with increasing control over his dynamic expression. The inter-musical relationship in the dialogue part consists of contrasting and complementary elements, while from bar 31 onwards it approaches – step by step – a uniform tonal image that appears identical in rhythm and timbre in bars 38–41 (Figure 12.18).

Consequently, we may ascertain that the patient, after synchronizing first the rhythms for himself, is able to take up the therapist's rhythmic structure, follow it and enter into the development of a synchronous, interactive play with her. His determination becomes manifest, triggers their interactive play and determines the light and playful character of this episode.

The therapist recorded her personal impression of this episode and the patient as follows: 'We play together, quite informally. I may have confidence; let's be relaxed about it.'

#### *Development towards interactive play: Episode 4*

In between Episodes 3 and 4 there is a forcefully played section with galloping rhythms which in Episode 3 (bars 19–20) stood out as a typical feature of the patient's mode of play. The start of Episode 4 indicates the end of this section (see Figure 12.19).

This episode again starts with the search category. Subsequently, the category determination prevails. The category orientation appears in one example only and therefore plays a minor role in this context.

#### SEARCH

The end of the previous section becomes evident in the patient's voice as a gradual dissolution into single elements that change over to a singular appoggiatura motif (compare Episode 3). This reduction to a singular element initiated by the patient characterizes the process of search for a new and different mode and form of expression. The development reaches a 'standstill' in bars 6–7 (see Figure 12.20). What was presented before in a clear and forceful fortissimo play and quick allegro pace, now becomes open and indeterminate.

The musical score is divided into three systems, each featuring a Patient (Conga) part and a Therapist (Piano) part.

**System 1 (Measures 1-3):**

- Tempo:**  $\text{♩} = 120$
- Patient (Conga):** Measures 1-3 show rhythmic patterns with 'x' marks indicating hits. Dynamics include *mf* and *ff*.
- Therapist (Piano):** Measures 1-3 show a complex piano accompaniment with chords and moving lines in both staves. Dynamics include *ff*.

**System 2 (Measures 4-6):**

- Patient (Conga):** Measures 4-6 show rhythmic patterns. Dynamics include *mf* and *p*.
- Therapist (Piano):** Measures 4-6 show piano accompaniment. Dynamics include *mp*.

**System 3 (Measures 7-9):**

- Tempo:**  $\text{♩} = 50$  (variable)
- Patient (Conga):** Measures 7-9 show rhythmic patterns. Dynamics include *pp* and *pppp*.
- Therapist (Piano):** Measures 7-9 show piano accompaniment. Dynamics include *p* and *pp*.

Figure 12.19 Episode 4

continued on next page

The musical score for Episode 4 continued, measures 15-23, is presented in four systems. Each system consists of a Piano (P.) part and a Theremin (Th.) part.

- System 1 (Measures 15-16):** The Piano part features a series of chords with a crescendo leading to a *mp* dynamic. The Theremin part has a melodic line in the right hand and a sustained chord in the left hand.
- System 2 (Measures 17-18):** The Piano part continues with a melodic line and a crescendo leading to a *mf* dynamic, followed by a *p* dynamic. The Theremin part has a melodic line in the right hand and a sustained chord in the left hand.
- System 3 (Measures 19-20):** The Piano part features a series of chords with a tempo change to 40 (marked with a quarter note). The Theremin part has a melodic line in the right hand and a sustained chord in the left hand.
- System 4 (Measures 21-23):** The Piano part features a series of chords with a tempo change to 90 (marked with a quarter note). The Theremin part has a melodic line in the right hand and a sustained chord in the left hand.

Figure 12.19 Episode 4 continued

continued on next page

Figure 12.19 Episode 4 continued

Figure 12.20 Episode 4: bars 5–7

In bar 8, the patient starts to express himself at a slow pace, still indeterminate and without definite shape (see Figure 12.21). The therapist frames her first sound with a diminished chord and resolves this in an upward line as soon as the patient has signalled his further play with two more notes. The therapist's rising melody reintroduces a flowing element into the musical play to which the patient responds.

Figure 12.21 Episode 4: bars 8–9

His search again becomes evident in the characteristic crescendoing tremolo, which he transports into three clear notes. The metre is variable and open.

#### ORIENTATION

The musical example of the orientation category is preceded and followed by an example of the determination category in each case. This means that a new constellation emerges with bar 20 (see Figure 12.22). The patient finds orientation in the therapist's voice. This appears in the form of a monophonic melody phrase that unfolds in a close note-by-note relationship with the patient. In repeating the individual melody notes with some strong accents, the patient delays and accelerates his playing in such a way that a fluid melody movement becomes impossible. Consequently, metre and form of beat appear variable, too, although the underlying melodic form (half-phrase), which may be anticipated, supports the play of both. In bar 22, the upward melody line is even more sustained by the patient's retarding play. Via the fermata ( $f^2$ ) it reaches  $g^2$  as the highest note.

#### DETERMINATION

The above example of the orientation category also underlines the fact that the patient anticipates the melody contour. He is thus able to newly decide in the



Figure 12.22 Episode 4: bars 20–22

following bar 23 and to pursue the melodic phrase started by the therapist into the half cadence (see Figure 12.23). With the descending melody line the patient decides on an unequivocal tempo in a clearly defined form of beat. He refers directly to the melody line, which he closely accompanies in a fluid quarter-quaver movement.

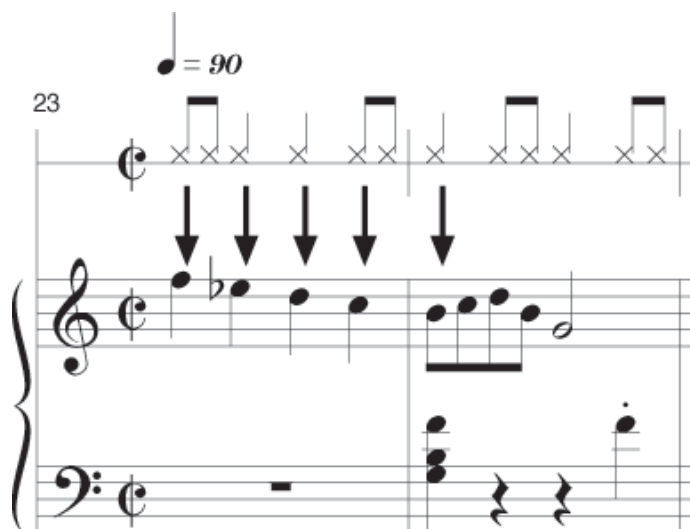


Figure 12.23 Episode 4: bars 23–24

The following example of the determination category follows immediately upon bar 24. It illustrates the patient's consistent accompanying motif which he varies in relation to the melodic motifs and the four-beat phrase (see Figure 12.24). We may also observe how the patient varies his rhythmic accompanying motifs in relation to the ascending melody line (see Figure 12.25). This is obvious in bar 30, where he



analogically stresses the climactic note of the melody ( $g^2$ ) with a rhythmic prolongation (dotted quarter note).

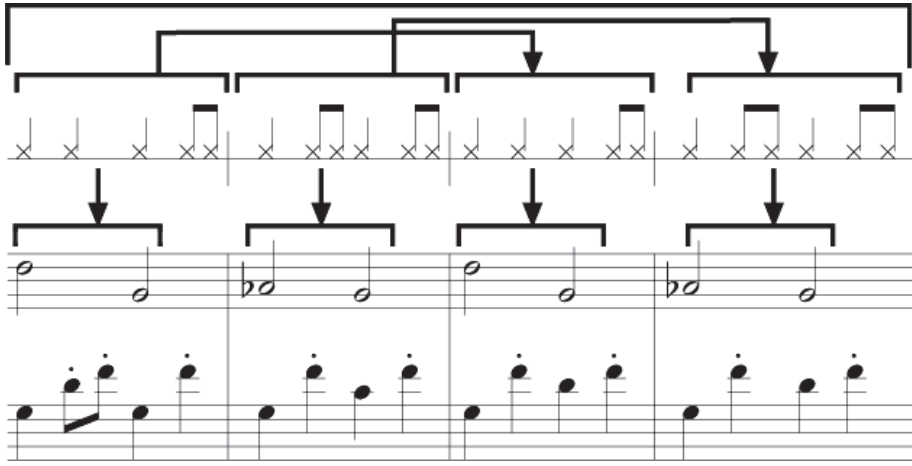


Figure 12.24 Episode 4: bars 25–28



Figure 12.25 Episode 4: bars 29–30

The last example of determination refers to the beginning of the episode (see Figure 12.26). Bars 18–19 show that the patient is able to give up his superficial expression (tremolo effects), changes over to a clearer appoggiatura motif and concludes the previous complementary play with a soft crochet accent. This final turn was already announced with the therapist's descending line (bar 18), which probably gave the impulse for his appoggiatura motif.

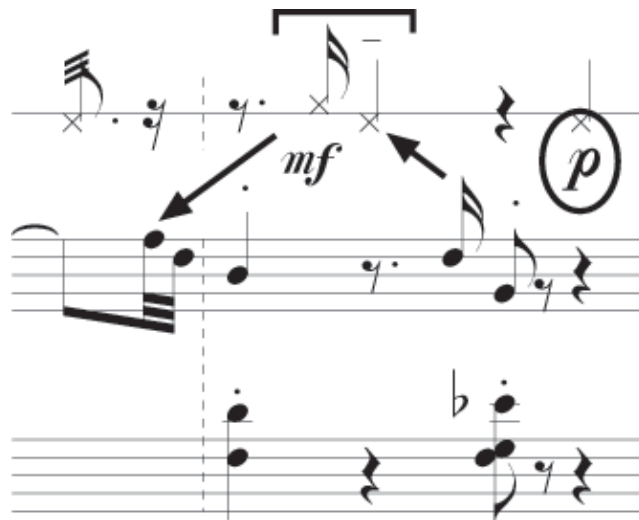


Figure 12.26 Episode 4: bars 18–19

Episode 4 demonstrates even more clearly the patient's ambivalence between fleeting, non-committal phases concentrating on the surface structure of the musical material, and distinct and well-articulated phases with rhythmic–melodic statement. These phases reflect the patient's relation with the therapist and vice versa. Clear structures, dominated by the therapist (she defines the relationship with the clarity and stringency of the musical statement) cause the patient to reduce his play and thus induce a change in the relationship, which appears variable, loose, open and non-committal. The therapist senses an element of distance and views the patient's reaction also as a withdrawal from their jointly concluded, active and expressive music-making. The patient's expression here is fleeting, *en passant*. This is by no means a negative development; rather, it illustrates the process of a developing therapeutic relationship.

The change from a variable to a more committed statement, undergone by the patient in one step (bars 22–23), constitutes an advance in the therapeutic relationship. Moreover, it underlines the significance of this episode for melodic development. In this episode we know that the patient perceives melody lines, anticipates her tendencies in the pitch direction, establishes a relation and performs together with her. The fact that the patient, in joint music-making with the therapist, is able to clearly express himself in melody and sustains the relationship is evidence for her that melody means something to him. The relation with the melody enables him to stress moments of form by responding to half-phrases and phrases and stressing these with the sound of the low centre of head (bars 29–32).

In addition, these phrases reveal the changeability and developmental character of the two categories orientation and determination.

The therapist's personal notes on this episode (here again, related to the patient and herself, in the form of a personal dialogue): 'We are approaching each other in melodic play and share the melodic flow.'

### *Development towards interactive play: Episode 5*

Episode 5 is the continuation of Episode 4 and constitutes the end of the second improvisation in the first session (see Figure 12.27).

The musical score for Episode 5 is presented in three systems. The first system, measures 1-4, features the Patient (Conga) part with a tempo of 100 and a 'Moderato' marking. The Therapist (Piano) part is marked *mf*. The second system, measures 5-8, shows the Patient part marked *mp* and the Therapist part marked *mp*. The third system, measures 9-12, shows the Patient part marked *ppp* and the Therapist part marked *rit.* and *ppp*.

Figure 12.27 Episode 5

Episode 5 as the last example belongs to the group of four in the grid analysis with the significance ‘development towards interactive playing’. Within this context, Episode 5 brings two new categories: transformation and self-discovery. Both categories are interconnected and mutually dependent.

#### TRANSFORMATION AND SELF-DISCOVERY

In this episode, the patient continues his independent rhythmic accompaniment to the melody, established already in Episode 4, with high ringing drum notes, varied occasionally with dotted quarters (bar 1).

In bars 2–4 we find a musical example of transformation and self-discovery (see Figure 12.28). The patient interrupts his rhythmic accompanying motif with a rest in bar 2 on the last beat. This may be considered as a response to the shortly articulated thirds in the therapist’s voice. The therapist takes up the quarter rest, integrates it into the two subsequent bars and thus eases the melody line. Thus, the notes  $es^2$  and  $d^2$  with added chords appear on the second and fourth beat, which produces a rhythmic–syncopated effect.



Figure 12.28 Episode 5: bars 2–4

The patient immediately grasps the shape of the melody line interspersed with rests and complements on beats one and three. While he still goes back to his rhythmic accompanying motif in bar 3, he fully concentrates on the interactive play with the therapist in the following bars and transforms his play so that interactive

music-making becomes possible. Both patient and therapist contribute to the lively character of this section with their specific articulations.

The second example of this category appears in bars 5–6, where the melodic conclusion with the fifth motif  $g^2-c^2$  and its inversion  $g^2-c^3$  announces the end of the improvisation (see Figure 12.29). The melodic upper part is accompanied by a flowing upward line in bass. The sound of note  $g^2$  which is rhythmically augmented in bar 6 is stressed here.

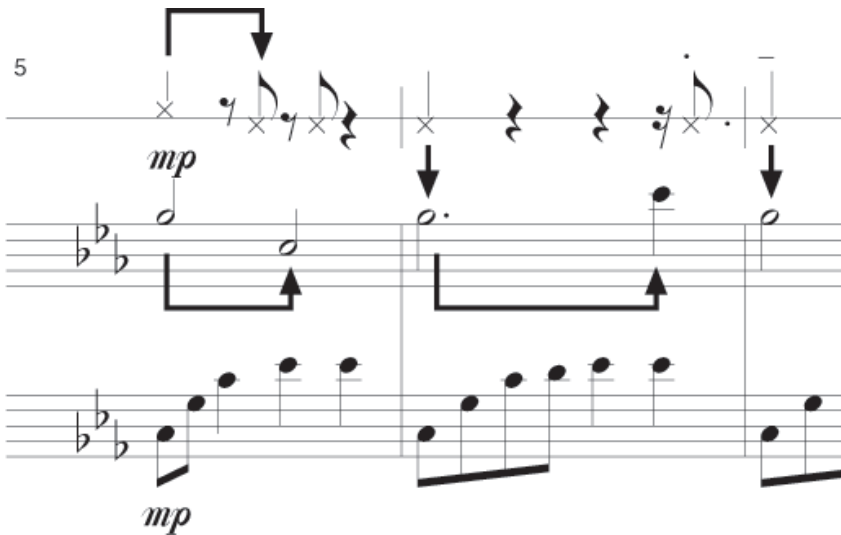
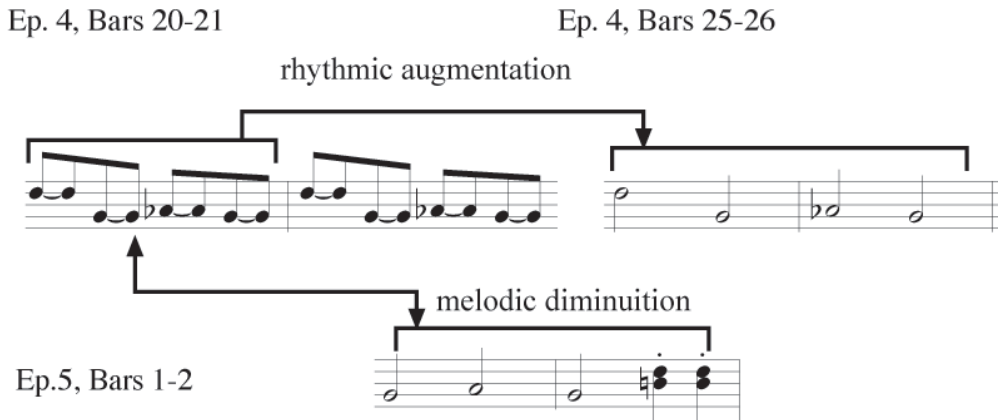


Figure 12.29 Episode 5: bars 5–6

In this example, the patient refers not only to the melodic motif (represented by the fifth) but also to the note  $g^2$ . He modulates the descending fifth with a change in expression from a high to a lower sound; he stresses the note  $g^2$  similar to Episode 4. In a corresponding prolongation he gives it space and continues the musical flow only with a slightly articulated quaver note.

Transformation becomes evident in the therapist's musical–melodic material as well. Starting with the emergence of the melody in episode four (bars 20ff), a key establishes itself for the first time (C-minor harmonic) and is sustained up to the end of the improvisation. Together with the substance of melody/motif, this determines the formation of phrases with two, four and eight beats. The excerpts in Figure 12.30 show the modifications and transformations within the melodic motifs.

Bars 25–26 constitute a rhythmic augmentation of the melodic motif from bars 20–21 and thus emphasize the melodic interval of the fifth even more. Bars 1–2 of Episode 5 are a melodic diminution of the melodic motif (Bars 20–21), which appears in a rhythmic augmentation similar to bars 25–26 (see Figure 12.30).



*Figure 12.30 Rhythmic augmentation and melodic diminution*

#### SELF-DISCOVERY

The musical example of the category self-discovery develops out of the previous examples. Here, self-discovery means an approach towards the more conscious self. This becomes audible in the patient's deliberate reference to, and concentration on, a melody note, to which he lends space by prolonging it in combination with a darker timbre. He thus provides more space for himself to experience a resonance within himself and to find subtly shaded modes of expression.

Episode 5 shows that the patient, given the chance to transform his musical voice, expands his creative modalities of play and finds individual expression. In the context of the concluding melodic fifth, both voices are linked in an affirmative statement that allows the joint music-making to gradually fade out. The patient sustains his mode of play continuously up to the end. In this calm final turn, he discovers his self in a very subtle and delicate expression that fades out in *ppp* (see Figure 12.31).

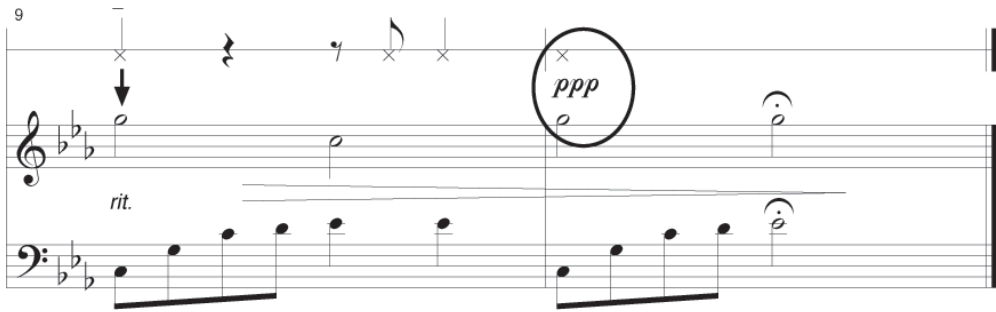


Figure 12.31 Episode 5: bars 9–10

## Building up the intra- and inter-musical relationship (Episodes 6–10)

### *Building up the intra- and inter-musical relationship: Episode 6*

Episode 6 represents the beginning of the first improvisation in the second session. The second session is dominated by the tom-tom, which gives two different pitches. The patient plays with two sticks, accompanied by the therapist on the piano (see Figure 12.32).

This category is determined by the search category, which becomes evident in various musical characteristics. The first four bars of this episode provide the first example (see Figure 12.33).

The patient starts with an appoggiatura motif in forte, which we know from the previous episode. He repeats it in graduated, softer dynamics. The therapist takes it up in rhythmic augmentation and dissonant timbre (tritone, tension of a seventh) and tries to bind it in a 4/4 time (bars 1–2), keeping the tonal space open. In the third bar, he diverts from this motif and in very soft intonation (pp) searches for a metric base. However, he interrupts with strong dynamic and accentuation. In bar 4, the therapist takes up the measure started by the patient as the metric foundation for her four-time phrase.

In the subsequent bars, the patient continues his indeterminate, aimless playing. An excerpt from bars 5–8 shows in the patient's voice that he lines up single rhythmic patterns, some of which do not make musical sense and are not interrelated (see Figure 12.34). His dynamic form appears unstructured and strung together at random by way of the immediately succeeding and strongly contrasting expressions ppp – mf, or pp – f.

(senza misura)

1

Patient (Tom Tom)

Therapist (Piano)

5

P.

Th.

9

P.

Th.

Figure 12.32 Episode 6

The therapist continues the phrase started in beat four in a fluent tempo in very soft intonation (p), guiding the melodic contour in a very close line (minor second, minor third) from  $c^2$  to  $gis^1$ . In bar 8, she modifies the onset of the melody with an inversion of the motif. The melodic formation emerges from the sound of the minor seventh and cannot be bound in harmonic function. The dominance of the tritonic sounds ( $gis^1 - c^2$ ;  $f^1 - h^1$ ) creates an iridescent effect with a sometimes strong tonal tension that is not resolved.



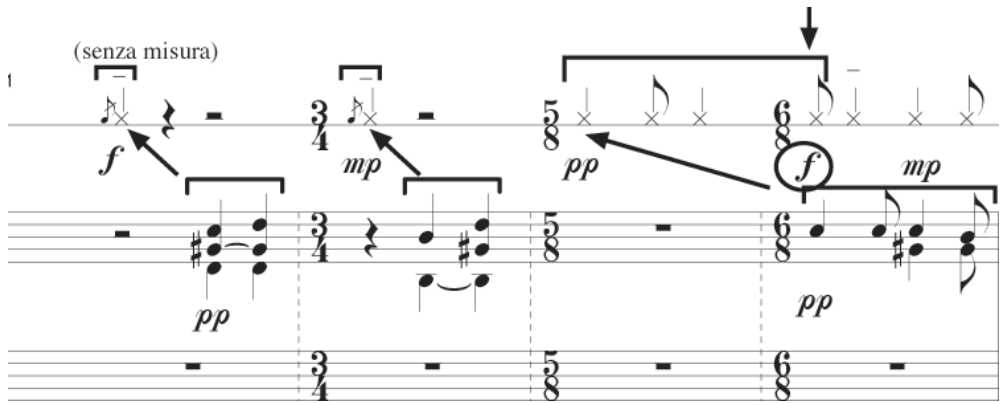


Figure 12.33 Episode 6: bars 1–4



Figure 12.34 Episode 6: bars 5–8

Episode 6 forms a contrast to the previous episode. Here, the patient struggles to find, perceive and define his self. His playing is caught up in sporadic action, with no access to a continuous musical flow, illustrating the contrast between the patient's vague and unrelated play and the therapist's shaped expression. We may even detect an adverse reaction on the part of the patient, triggered by the therapist's repetitive play with a clearly defined tonal character and accentuation, by stressing the first part of the bar (bars 8 and 10). The clearer one voice becomes (therapist), the more unclear the development of the other (patient). We gain the impression that both voices are running in parallel, but without relation, or even contrary to each other.

### *Building up the intra- and inter-musical relationship: Episode 7*

Between Episode 6 and the beginning of Episode 7 we hear a searching play of two minutes with the characteristic features of Episode 6. Just before Episode 7 begins, the therapist introduces a short, musical intensification in an even metre of 6/8 and concludes with an immediately following rest. She thus sets a clear caesura in the musical sequel. The beginning of Episode 7 constitutes the onset of the patient's play after this caesura (see Figure 12.35).

In this episode, the focus is on the category of orientation. The determination category is represented in one example.

The musical score for Episode 7 is presented in four systems, each with a Patient (Tom Tom) part and a Therapist (Piano) part. The time signature is 6/8.

- System 1 (Measures 1-4):** The Patient part consists of a series of 'x' marks on a staff, indicating a rhythmic pattern. The Therapist part begins with a piano (*pp*) dynamic, featuring a series of chords in the right hand and rests in the left hand.
- System 2 (Measures 5-8):** The Patient part continues with 'x' marks. The Therapist part continues with piano (*pp*) chords in the right hand and rests in the left hand.
- System 3 (Measures 9-12):** The Patient part continues with 'x' marks. The Therapist part begins with a fortissimo piano (*sfp*) dynamic, featuring a series of chords in the right hand and rests in the left hand. The word *stretto* is written below the right hand part.
- System 4 (Measures 13-16):** The Patient part continues with 'x' marks. The Therapist part continues with fortissimo piano (*sfp*) chords in the right hand and rests in the left hand.

Figure 12.35 Episode 7

## ORIENTATION

After the caesura, the patient again starts with his play, taking up very softly (*pp*) the previous metre of 6/8 (see Figure 12.36). He thus finds his bearings in the previous part and in the middle tempo range takes up the 6/8 metre as a starting point for his play. As early as in bar 2 he adds accents on the first beat and thus underlines the rhythmic structure.

The therapist accompanies him in a high pitch with tritonic chords, starting with the second eighth and clearly transposing them towards the patient's accent. The successive development of the highest chords underlines the melodic interval of the minor third.

Figure 12.36 Episode 7: bars 1–3

The second example of the orientation category becomes apparent in bars eight and nine (Figure 12.37). The patient maintains the 6/8 metre and intensifies the bar accent (first quavers) by adding the second, darker drum in parallel play. The therapist's accompanying voice remains unchanged.

Bars 12 and 13 give us the last example of orientation, after the example of the determination category. In both bars, the 6/8 metre still forms the basis for the patient's play. As a consequence of the previous change in the therapist's voice, which now is no longer accompanying but rather has an enforcing and intensifying effect due to the transition to the throbbing quaver time, the patient is looking for alternatives. These become apparent in the form of semiquaver interpolations on the second (bar 12) and last quaver (bar 13) – see Figure 12.38.

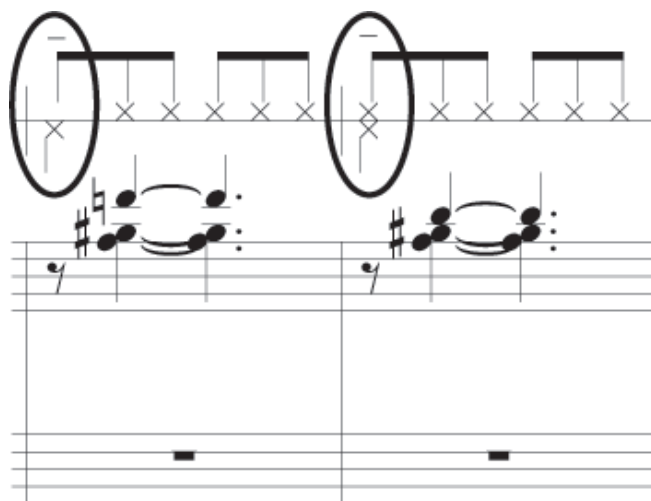
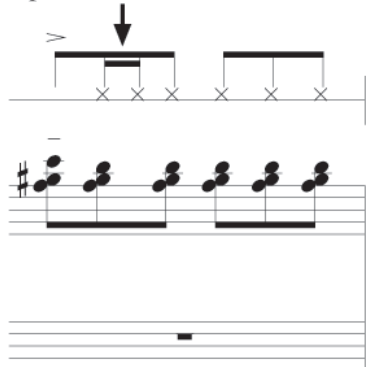


Figure 12.37 Episode 7: bars 8–9

#### Ep. 7, Bar 12



#### Ep. 7, Bar 13

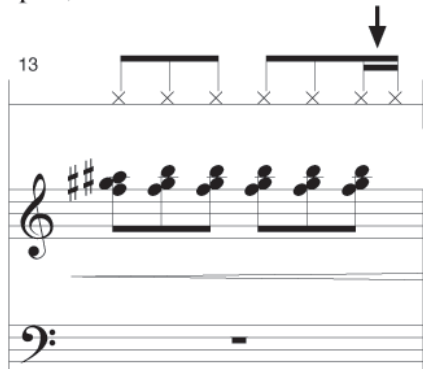


Figure 12.38 Episode 7: bars 12 and 13

#### DETERMINATION

The example of *determination* may be seen in bars 10 and 11 (see Figure 12.39). It develops out of the previous example of the orientation category (bars 8–9) and in bars 10 and 11 emerges as a purpose and decision for a particular dynamic interpretation: *sfp*, with an additional accent in bar 11. The patient thus deliberately emphasizes contrasts. This determination in the patient's play induces the therapist to follow him, to take up the throbbing quaver time and also the bar accents. In doing

so, she changes the course of the highest notes of her tritonic/third sounds, which now emerge in chromatic line. The continuously sustained high pitch, the moderate tempo – and increased volume (*stretto* and *crescendo*) – render the playing more intensive in sound.

Figure 12.39 Episode 7: bars 10–11

In this episode, the focus is on the orientation category. Compared to Episode 6, the patient no longer looks for a possible form but finds his bearing from the very beginning in the previous regular quaver rhythm. With his constant playing over eleven bars, the patient is able to maintain contact with the metre for a rather long period. He seems to make this metre his own. This may be because the therapist's music stands out from his own at the beginning of this episode. She has created a situation that is the reverse of the previous episode – here the therapist leaves the clarity of the metre, while the patient sustains it continuously.

A moment of insecurity emerges in the patient's play when the therapist matches her play to his and thus produces an almost identical sound. His semiquaver interpolations may be considered as his response, interrupting not only the musical flow, but also the gradually developing intensification. It may well be that in this intensity of expression, and the almost identical musical structure, the patient experiences the closeness of the therapist as too much and he has to find his bearings again in order to create a psychological distance.

With the intention of building up an intra- and inter-musical relationship, the significance of this episode may be seen in the fact that the patient experiences himself in his orientation to metre within the same strong tonal expression. He

experiences not only his inner restlessness, agitation and tension but also his personal creative resources.

### *Building up the intra- and inter-musical relationship: Episode 8*

Episode 8 represents the start of the second improvisation in the second session (see Figure 12.40). The categories search, orientation and determination play a role in this episode. They emerge in the course of this episode and follow from each other to some extent.

The musical score for Episode 8 is presented in three systems. The first system shows the Patient (TomTom) and Therapist (Piano) parts. The Patient part begins with a single note on a staff with a treble clef, marked *p* (piano) and *mf* (mezzo-forte). The Therapist part is in piano and features a series of chords in the right hand and single notes in the left hand, both in a key with two sharps (F# and C#). The second system shows the Patient part with a tempo marking of  $\bullet = 100$  and a series of notes marked *p* and *fp* (fortissimo piano). The Therapist part continues with chords and single notes. The third system shows the Patient part with a series of notes marked *fp* and *p*, and a final measure with a fermata. The Therapist part continues with chords and single notes, ending with a fermata and a final note marked *2*.

Figure 12.40 Episode 8

## SEARCH

The episode starts with the search category. After a soft quarter beat on the higher drum, the patient changes over to a tremolo with a decrescendo in the course of bars 3–4. This category thus commences in a still indeterminate and vague mood. In bar 4, the patient concludes the fainter tremolo with a quarter beat, as inversion of bar 1, thereby not only putting an end to the unclear statement of the first phase but also setting up a caesura with the quarter beat, which at the same time forms the transition to the orientation category (see Figure 12.41).

The therapist supports the patient's tremolo with harmonic chord sequences (B-minor; C-sharp diminished; B-minor) and a structured beat (alla breve).

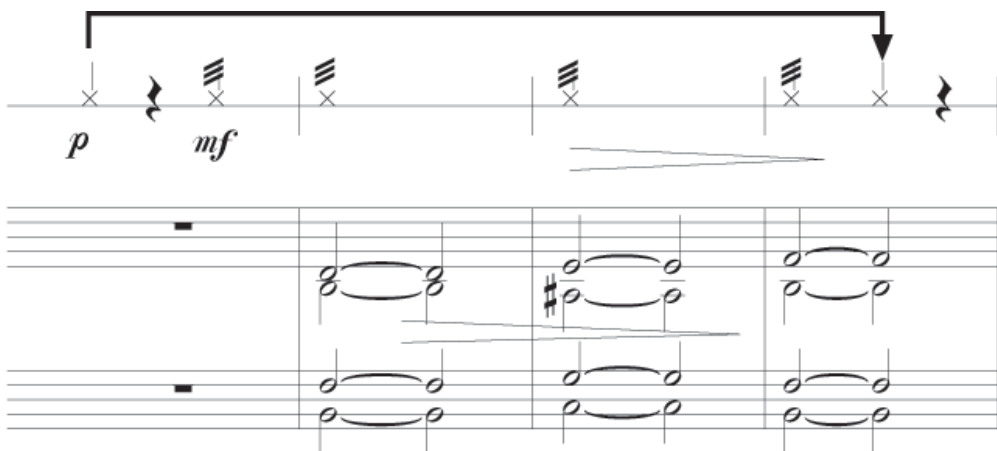


Figure 12.41 Episode 8: bars 1–4

## ORIENTATION

Bar 5 illustrates how the patient turns towards the orientation category (see Figure 12.42). Here he pauses in order to tune in to a new form of play, which he takes up on an upbeat in the following bar 6. With reference to the alla breve beat, he creates a metric base, which he accentuates according to the beat accents but also syncopates. Simultaneously he has found a clear and fluent andante tempo.

In bar 7, the therapist adjusts to the new measure and starts to give the upper part of the chord sequences a stronger rhythmic accentuation in accordance with the patient's voice.

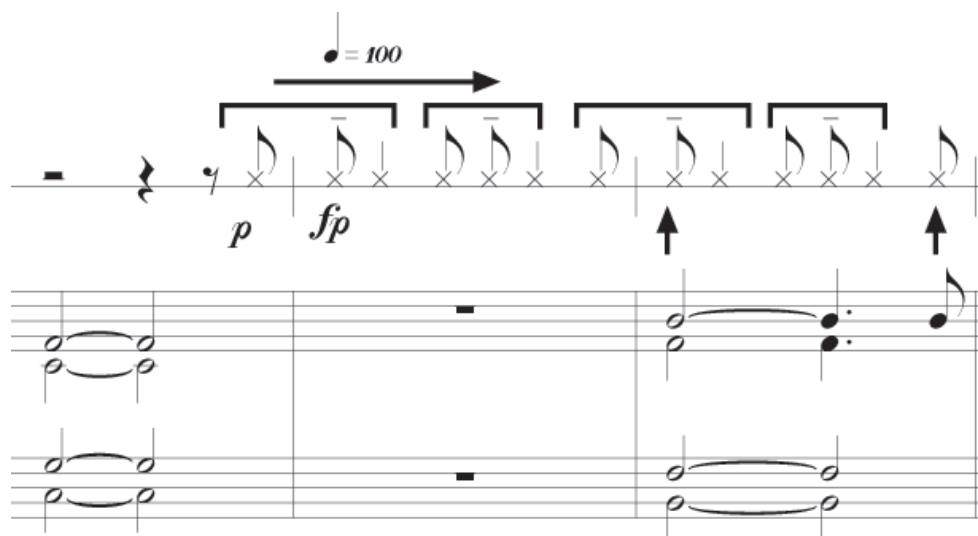


Figure 12.42 Episode 8: bars 5–7

#### DETERMINATION

This category follows immediately upon orientation; in other words, his orientation enables him to determine to take his play into both hands and to articulate it in sound and dynamics (introduction of the deep drum on the first beat). Simultaneously he varies the rhythmic process in taking up the therapist's punctuation. From bar 11 onwards he turns over to a two-voice mode; he now employs the dark sound of the drum as a counterpart or accompaniment to his evenly sustained rhythmic upper voice.

The therapist's melodic voice starting in bar 7 and emerging from the harmonic sequences supports the patient's rhythmic voice in a continuously descending contour from  $b^1$  (bar 7) to B-minor (bar 11), maintaining for the most part the harmonic alternation between B-minor and C-sharp diminished (Figure 12.43).

Episode 8 outlines a rapid development passing through the categories of search, orientation and determination. After an indeterminate and vague beginning, the patient finds orientation in his own voice (the therapist offering nothing but the measure as a frame), takes this as a metric base and settles on it, building up lively tonal, dynamic and syncopated effects. The point is that here he does not turn away from his playing but sustains it throughout. This helps him to intensify his intra-musical relationship. Despite this clear and definite musical statement, his presentation and expression are characterized by restraint (*p*). The therapist feels that something prevents him from expressing himself in a clear and unmistakable manner. Her personal comment on this episode is: 'A tentative experience of repetition, of keeping the ball rolling.'



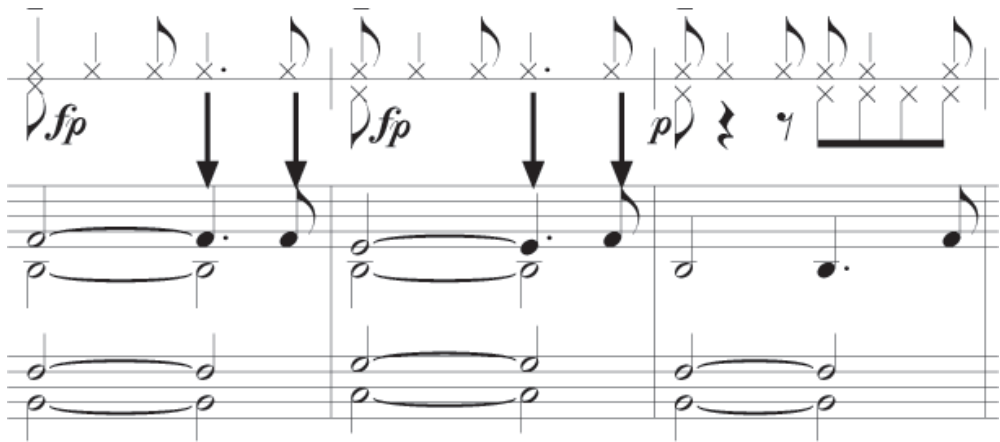


Figure 12.43 Episode 8: bars 9–11

### *Building up the intra- and inter-musical relationship: Episode 9*

Episode 9 originated over the course of the third improvisation in the second session. The patient begins the third improvisation forthright, in vigorous intonation and clear rhythmic expression. However, the clear expression gets lost very soon in appoggiatura motifs, rolls and quickly changing unclear accents. At the onset of episode 9, the patient has regained contact with his play (see Figure 12.44). In this episode we can find examples of the categories of orientation, transformation and determination.

#### ORIENTATION

In the first example representing the orientation category (bars 1–4), the music is arranged in clear two-time phrases, with a stress on the pitch structure (see Figure 12.45). The melodic intervals forth and fifth form an ascending contour in even quaver movements, while the downward line stresses the triad in C-minor, which also forms the tonal accent in this improvisation. The directional change in pitch is stressed even more clearly by the contrast of legato and staccato.

This example illustrates that the patient's rhythmic play follows the ongoing pulse of the even measure (4/4 time) and the pitch structure. The patient is carried away with the first two quavers in bar 1, and this already underlines the strong effect of the ascending figure in C-minor. During the first two-time phrase he places his characteristic appoggiatura motif in relation to the highest note ( $g^3$ ) of the melodic ascent. In repeating the melodic ascent in bar 3, he gives himself room (pause) in order to take an active part in shaping the descending staccato contour.

The musical score is written for two parts: Patient (Tom Tom) and Therapist (Piano). The key signature is B-flat major (two flats) and the time signature is 4/4. The score is divided into three systems, with measures 6, 11, and 14 marked at the beginning of each system.

**System 1 (Measures 1-5):**

- Patient (Tom Tom):** The notation uses 'x' marks on a staff to represent drum hits. The pattern starts with a series of eighth notes, followed by a quarter note, and then a series of eighth notes with rests.
- Therapist (Piano):** The right hand plays a melody starting on G4, moving up stepwise to B4, then down to A4, G4, and F4. The left hand plays a bass line starting on B2, moving up stepwise to D3, E3, and F3. Dynamics include *mp* (mezzo-piano) and *8va* (octave up) markings.

**System 2 (Measures 6-10):**

- Patient (Tom Tom):** The pattern continues with a series of eighth notes, followed by a quarter note, and then a series of eighth notes with rests. Dynamics include *mf* (mezzo-forte) and *p* (piano) markings.
- Therapist (Piano):** The right hand plays a melody starting on G4, moving up stepwise to B4, then down to A4, G4, and F4. The left hand plays a bass line starting on B2, moving up stepwise to D3, E3, and F3. Dynamics include *mf* (mezzo-forte) and *p* (piano) markings.

**System 3 (Measures 11-14):**

- Patient (Tom Tom):** The pattern continues with a series of eighth notes, followed by a quarter note, and then a series of eighth notes with rests. Dynamics include *mf* (mezzo-forte) and *p* (piano) markings.
- Therapist (Piano):** The right hand plays a melody starting on G4, moving up stepwise to B4, then down to A4, G4, and F4. The left hand plays a bass line starting on B2, moving up stepwise to D3, E3, and F3. Dynamics include *mf* (mezzo-forte) and *p* (piano) markings.

Figure 12.44 Episode 9



Figure 12.45 Episode 9: bars 1–4

The subsequent second example (bars 5–6) also shows that the patient pursues the two-time phrases (see Figure 12.46). His rhythmic form has individual features and becomes lively, with rests on the first and fourth beats. The darker drum sound he has chosen appears in analogy to the descending line of the motif.

We may assume that the therapist's varied play emerging with bar 5 is a response to the patient's clear and well-shaped reference in bar 4; starting with bar 5, she concentrates on the shortly articulated, descending motif (bar 4), which she varies over

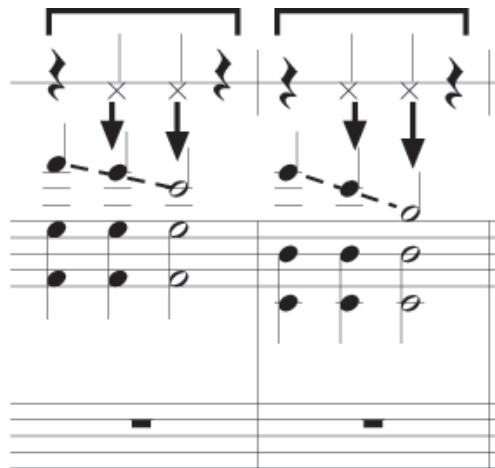


Figure 12.46 Episode 9: bars 5–6

the following bars, harmoniously alternating between F-minor<sup>7</sup> and C-minor<sup>7</sup> in the form of sequences and inversions.

#### TRANSFORMATION

In bar 9, the patient modifies his tonal expression in close relation to the pitch direction, which he anticipates and transfers to the higher drum, accentuating simultaneously with the highest note (c<sup>3</sup>) – see Figure 12.47.



Figure 12.47 Episode 9: bar 9

In the next examples, too, the patient follows the pitch direction and again takes up his rhythmic motif of bar 4 (see Figure 12.48).

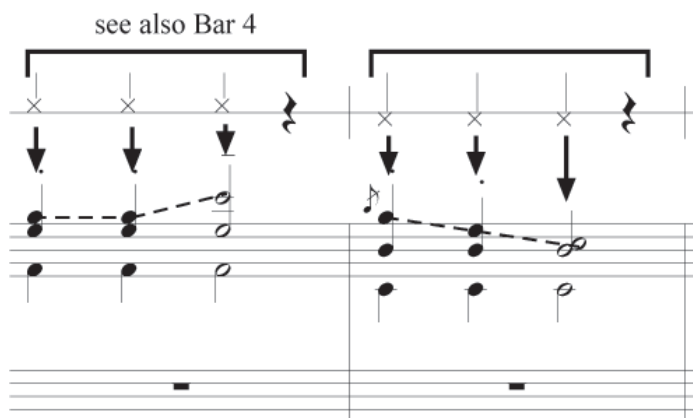


Figure 12.48 Episode 9: bars 11–12

## DETERMINATION

The determination category (bars 13–14) emerges here in the form of the stronger dynamics (*mf*, *sfz*) and rhythmic gestalt (see Figure 12.49). In connection with the dynamic shape, the patient here decides on a new rhythmic expression which he sustains over the following bars, where he vigorously increases the accentuation (bars 14–15) and thus reveals not only his preference for contrasts and tonal effects but also his difficulties to control his own impulses.

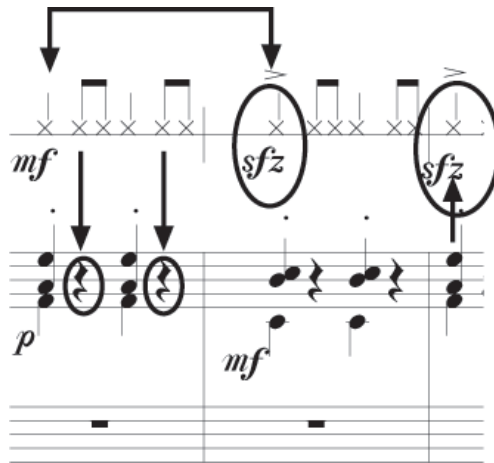


Figure 12.49 Episode 9: bars 13–14

In view of the new rhythmic–dynamic intonation on the patient's part, the therapist varies her pattern, introducing rests and reducing her dynamic input. While articulation and harmonious alternation remain unchanged, the pitch structure shows smaller distances.

The last example of this category appears in the acceptance of an appoggiatura motif as a new element of expression that was part of the therapist's voice in bar 12. With this immediate acceptance and inclusion of new expressive elements, the patient demonstrates his capability of interactive music-making (see Figure 12.50).

This episode shows an advancement in the intra- and inter-musical relation in the patient's play. His ability to perceive and anticipate helps him to orient his playing in an interactive manner. A clear suggestion is contained in bars 3 and 4. The rest in the patient's voice indicates that he concentrates on the musical material and internally prepares for joint interactive music-making. His subsequent three crochet beats parallel the descending triad in C-minor (see Figure 12.51) indicate a deliberate mode of play that underlines the two-measure structure of this music. The

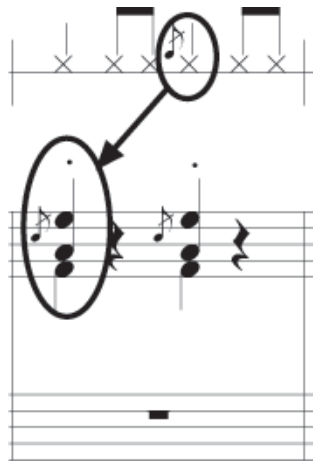


Figure 12.50 Episode 9: bar 17



Figure 12.51 Rhythmic form as a basis for interaction

rhythmic forms he develops form the basis of his patterns of interaction, which he then pursues in the joint play with alertness and concentration.

Another significant bar is 13, as it stands for the patient's determination to take the rhythmic and dynamic lead from then on. He succeeds in maintaining and controlling the rhythm but loses his hold on the dynamics, which appear unbalanced and even 'overshoot the mark' sometimes. The therapist is called upon here to reduce the energy in the clinical improvisation in order to preserve coherence and to prevent a disorganization that might disturb and confuse him.

This patient has a specific problem coping with his emotions, which becomes apparent in this and also several earlier episodes. The described quality of his musical commitment also reflects his clinical play, in particular his frequently shrill and loud dynamics with a tendency to overshoot in the generation of accents. This may indicate that this mode of playing which the patient is still unable to control must be interpreted in the light of the natural emotional unburdening or catharsis. His determination is fed here by his energy, which externalizes the emotional needs of expression in an unformed and 'raw' manner.

*Building up the intra- and inter-musical relationship: Episode 10*

Episode 10 forms the end of the third improvisation from the second session, subsequent to a section dominated by a lively quaver movement (see Figure 12.52). The therapist takes up this even quaver movement in the final turn and brings it to a conclusion. This episode belongs to the group of episodes that signify the building up of an intra- and inter-musical relationship. It is characterized by the determination category exclusively, which will be illustrated in more detail with two examples.

The musical score for Episode 10 is presented in three systems. The first system shows the Patient (Tom Tom) and Therapist (Piano) parts. The Patient part begins with a rest, followed by a series of eighth notes (quavers) marked *mf*. The Therapist part begins with a rest, followed by a series of eighth notes marked *f*. The second system shows the Patient part continuing with eighth notes, and the Therapist part continuing with eighth notes. The third system shows the Patient part continuing with eighth notes, and the Therapist part continuing with eighth notes, marked *ff*. The score is written in a key signature of two flats (B-flat and E-flat) and a common time signature (C).

Figure 12.52 Episode 10

## DETERMINATION

The patient's alternating movement and involvement of both drums produces a sound effect reaching from low to high. The therapist supports this movement with afternotes in accompaniment. She prepares the final movement with the gradually ascending upper voice ( $f^2$  to  $d^3$ ), the change to parallel chords and the modulatory resolution and intensification of the tonal frame by sharp dissonances (bass: C-sharp/ $d$ ; descant: A-flat/ $f/g$ ). The now evolving dynamics, which create a gradually building crescendo, cause the bar pattern to be given up (dotted bar-line).

Bars 2 and 3 show that the patient falls into line with the final intensification (see Figure 12.53). To this purpose, he gives up his alternations and, simultaneously to the therapist, concentrates first on the higher drum sound and then integrates both drum sounds in a parallel mode. He decides in favour of carrying this finale to the end in joint, simultaneous and consistent play.

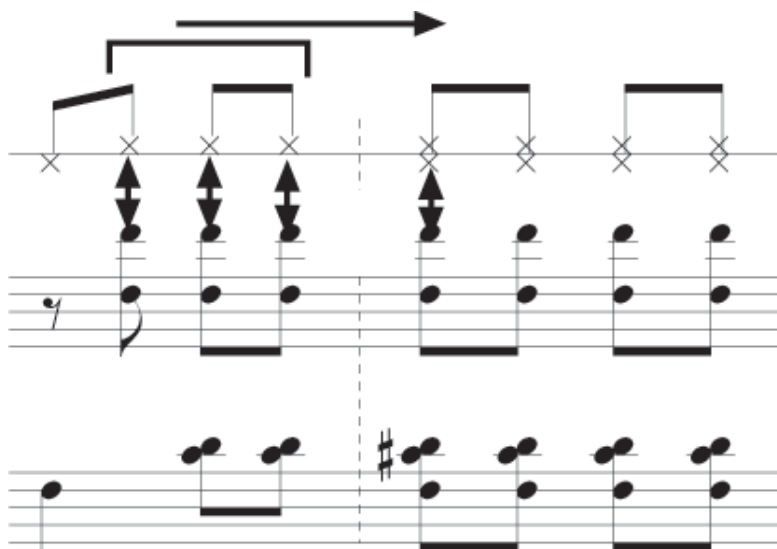


Figure 12.53 Episode 10: bars 2–3

The last two bars of this episode (see Figure 12.54) show that the patient not only increases the tonal intensity by even accentuation but is also able to change over to the final *ritardando* which announces the imminent culmination with the musical resolution. However, the patient again appears to deliberately avoid a consistent conclusion of the musical resolution towards G-major out of the previous joint process of intensification. He discards this alternative and instead decides on an added dynamic final roll.





Figure 12.54 Episode 10: bars 4–5

The patient's determination becomes manifest here in his turn towards an intensified inter-musical relationship. This close relation is sustained in its tight musical combination over the gradual built-up of the final intensification, almost to the culmination. The actual resolution of the musical process, realized in the G-major chord, is something the patient leaves to the therapist. He does not initiate his final movement with the chord of resolution but opts for a rest and adds an increasing and decreasing tremolo after the final note. Consequently, this episode reflects, on the one hand, the patient's clinical image of not being able to bring something to a definite conclusion, and, on the other, suggests that the patient searches for alternative forms that are more suitable to his current condition and allow for a different mode of expression.

### Musical creation in a melodically sustained relationship (Episode 11)

Episode 5 forms the beginning of the fifth improvisation in the second session. Although it is still part of the second session, it indicates a new phase in the process, with musical creation in a melodically sustained relationship as its contents. This phase, which emerged at the end of the second session, is defined exclusively by Episode 11, which is one of the longest episodes with 37 bars (see Figure 12.55).

In this episode we find the categories of orientation, search, determination, transformation and self-discovery. To some extent they emerge from each other, in part they appear in various constellations; for example, search – orientation – search, or determination – transformation, and transformation – self-discovery. The following musical examples substantiate the categories and give evidence of their characteristic properties.

## ORIENTATION

The first example of this category appears at the very beginning of the episode in bars 1–4. The patient starts his improvisation (bars 1–2) in a very soft and even mode. Accentuation and appoggiatura emerge very soon as typical features. After this first orientation, which appears somewhat insecure, the patient pauses. The therapist introduces a melodic figure in an appropriate even movement (see Figure 12.56). The motif of the ascending major seventh, repeated twice, is characteristic of

The musical score is divided into four systems, each with a Patient (Tom Tom) staff and a Therapist (Piano) staff. The Patient's part is written on a single staff with 'x' marks for notes, while the Therapist's part is written on a grand staff (treble and bass clefs).

- System 1 (Bars 1-4):** The Patient starts with a very soft (*pp*) improvisation. The Therapist responds with a melodic figure in the right hand, starting with a piano (*p*) dynamic. The key signature has one flat, and the time signature is 4/4.
- System 2 (Bars 5-8):** The Patient continues with triplets and accents. The Therapist's right hand features triplets and accents, while the left hand remains mostly silent. Dynamics range from *p* to *ppp*.
- System 3 (Bars 9-12):** The Patient uses a 12/8 time signature. The Therapist's right hand has triplets, and the left hand plays a steady eighth-note pattern. Dynamics include *pp* and *p*.
- System 4 (Bars 13-16):** The Patient continues with a 12/8 time signature. The Therapist's right hand has a melodic line, and the left hand plays a steady eighth-note pattern. Dynamics include *p*.

Figure 12.55 Episode 11

*continued on next page*

The musical score is presented in three systems, each containing three staves: Piano (P), Tenor voice (Th. voc.), and Tenor (Th.).

- System 1 (Measures 17-20):** The Piano part features a complex rhythmic pattern of eighth and sixteenth notes with many rests. The Tenor voice part is silent. The Tenor part provides a harmonic accompaniment with chords and moving lines in both hands.
- System 2 (Measures 21-23):** The Piano part continues with its rhythmic pattern. The Tenor voice part remains silent until measure 23, where it begins with a few notes marked *ppp*. The Tenor part continues its accompaniment.
- System 3 (Measures 24-27):** The Piano part concludes with a final rhythmic figure. The Tenor voice part continues with a melodic line. The Tenor part provides the final accompaniment.

Figure 12.55 Episode 11 continued

*continued on next page*

The image displays three systems of musical notation for a piece titled 'Episode 11 continued'. Each system includes staves for Piano (P.), Therapist's voice (Th. voc.), and Therapist's hands (Th.).

- System 1 (Measures 28-31):** The Piano part features a series of 'x' marks above the staff, indicating a specific rhythmic pattern. The Therapist's voice part has a melodic line with a fermata at the end. The Therapist's hands part consists of a complex, multi-measure rest followed by a melodic figure.
- System 2 (Measures 32-34):** The Piano part continues with 'x' marks. The Therapist's voice part has a melodic line with a fermata. The Therapist's hands part features a complex, multi-measure rest followed by a melodic figure.
- System 3 (Measures 35-37):** The Piano part continues with 'x' marks. The Therapist's voice part has a melodic line with a fermata. The Therapist's hands part features a complex, multi-measure rest followed by a melodic figure.

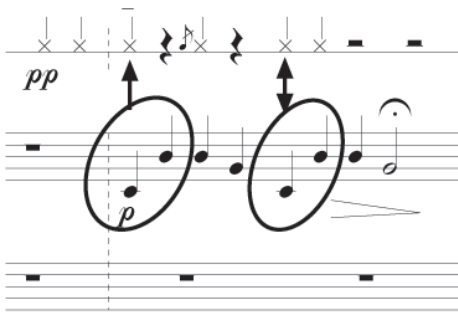
*Figure 12.55 Episode 11 continued*

her beginning. In accordance with the patient's rest, she lets the melodic figure ring out in a fermata.

After the pause, the patient starts again (bars 3–4), this time with a clearly audible two-measure rhythm, which is played very softly with a diminishing tendency but which takes the pattern of the dotted triplet and the slow pace as a basis for the new mode.

In bars 3–4 the therapist varies the melodic figure by augmenting the ambit from  $c^1$  to  $e^2$  (tenth). She refers to the patient's dotted triplet motif with the quaver triplet

## Episode 11, bars 1-2



## Episode 11, bars 3-4

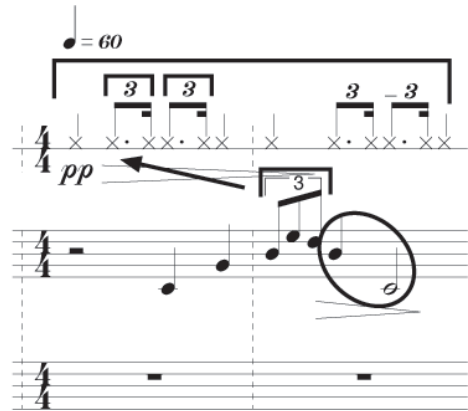


Figure 12.56 Episode 11: bars 1–2 and 3–4

in bar 4 and underlines the continuity of this melodic figure in the downward descending major seventh.

The second example of the orientation category appears immediately after bars 3 and 4 (see Figure 12.57). The patient develops various rhythmic patterns on the basis of his dotted triplet. However, it is not possible to identify a clear relation to a recognizable measure at this point. He concentrates on the sound of the high drum exclusively.

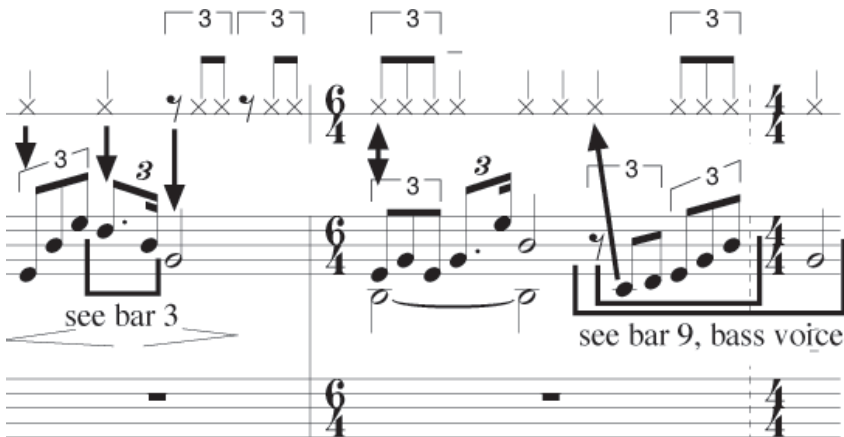


Figure 12.57 Episode 11: bars 5–6

Similarly, the therapist develops additional short melodic figures from the characteristic melodic interval of the major seventh, either ascending only, or descending as

well, and rhythmically related to the patient's triplet motif. She lets her melodically varied figures fade out with a half note and thus underlines the clarity and consistency of the coherent tonal figures.

#### SEARCH AND ORIENTATION

The example of the search category emerges in the patient's voice in the loss of contact with the triplet motif. The reason for the loss of this inter-musical reference is his impulse to subdivide (demisemiquaver notes). He again uses the rest for a new orientation that allows him to go back to his familiar triplet motif in bar 8. He finds orientation in the therapist's melodic voice, with which he enters into a complementary relation (see Figure 12.58).

The quaver note he accentuates in bar 9, is taken up by the therapist in a 'staccato–legato' articulation and transferred to an ascending bass figure (minor c to

Figure 12.58 Episode 11: bars 7–8 and 9

e<sup>1</sup>). In introducing the bass register, the therapist obviously reacts to the changed timbre in the patient's voice.

The following two examples also suggest a close constellation of the two categories search and orientation. Bars 10–14 are similar to bars 7–9 in this respect.

Accentuation and syncopation (bars 10–11) in the patient's play result in a loss of the metric basis (see Figure 12.59). The groups of three–eight notes in bar 10 may be interpreted as search for the metric background.

The therapist takes up the patient's groups of three–eight notes which she uses as concluding figures in the bass figure emerging in bar 9. The final fifth leaves room for caesura and new orientation. She thus creates a coherent line of motif groups to counteract the patient's instable mode of play.



Figure 12.59 Episode 11: bars 10–11

Another reorientation in the patient's voice takes place in bars 12 and 13 (see Figure 12.60). The patient 'waits' for a bass figure perceived earlier in the therapist's voice in bar 9 and after the quaver rest continues his play by analogy with the bass figure. Internally, he again takes up the three–eight metre and in bar 13 gives it the form of dotted quavers expressed with both drums. Apart from the major seventh, the therapist's voice displays the fifth, fourth and third as pitch intervals. The bass

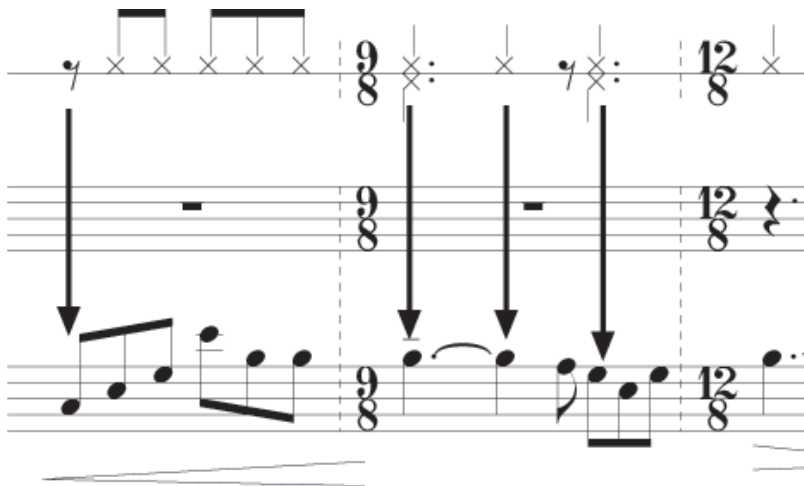


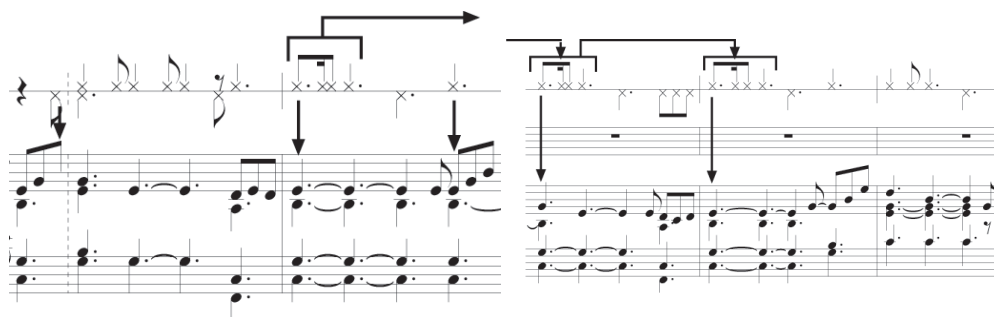
Figure 12.60 Episode 11: bars 12–13

figures of bars 9 and 12 appear as reminiscences of the ascending melodic line from bars 2 to 3.

#### DETERMINATION

In bars 15–18, the patient has reached a decision (see Figure 12.61). He starts to structure his play rhythmically in three–eight time, returning to the dotted triplet motif from bar 3 and expanding it by one quaver. The darker drum sound is now deliberately selected for the dotted crotchets as the basic rhythm of the emerging twelve–eight time, so that the music now appears swinging, animated in character and really begins to flow for the first time. In his rhythmic interpretation he relates to the therapist's theme in using his dotted triad motif at the beginning respectively and also in complementing the upbeat three–eight motif.

The clearer expression in the patient's rhythmic voice audible from bar 12 onwards



*Figure 12.61 Episode 11: bars 15–16 and 17–18*

induces the therapist to create a four-time theme with two repetitive parts, whereby the binding over at the end of the triad motif underlines the tonal range. A characteristic element in this is the three–eight tonal figure that leads over to the next bar on the last dotted basic beat crotchet in an upbeat and urges the movement along. This creation of themes is a result of the melodic figures of the initial bars and mainly concentrates on two harmonic chords including the major seventh: seventh chords in C-major and F-major.

#### DETERMINATION AND TRANSFORMATION

The transition from the category of determination to that of transformation becomes obvious in bars 19–21 (see Figure 12.62). Now the patient produces his dotted triad motif at the end of the bars, parallel to the therapist's upbeat triad figure, while the



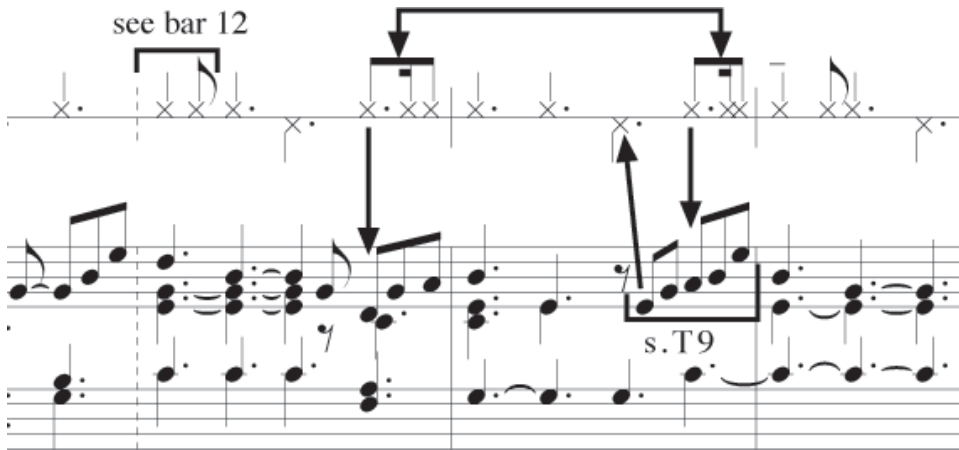


Figure 12.62 Episode 11: bars 15–21

dotted crotchets of the basic beat ring out consistently on the second and third beats. He stresses the beginning of a bar more strongly with the accented crotchet–quaver motif, which he first introduced in bar 12.

The therapist supports the patient with a varied repetition and expansion of the theme to eight bars.

#### DETERMINATION

With the onset of the therapist's vocal part from bar 24 onwards, which gives a soft timbre to the melody line of the theme, the patient's voice shows more and more dotted quaver figures which now appear on the first and fourth beats. His play has now a rather dense and restless quality (see Figure 12.63).

#### TRANSFORMATION

The change to transformation begins with the repetition of the theme (bars 26–27), which the therapist starts with  $c^1$  this time (see Figure 12.64). The melody voice again contains the major seventh as the characteristic melodic interval which is then guided to  $g^1$ . The therapist's vocal part appears in harmonic ostinato ( $c^1$ ). The patient is able to leave his dense mode of play and to concentrate more on the dotted crotchet in basic beat and the inclusion of rests. He thus gives himself more room and recovers the swinging, peaceful original measure.

Figure 12.63 shows musical notation for three parts: Patient, Therapist, vocal, and Therapist, piano. The Patient part is a single staff with 'x' marks and vertical lines indicating rhythm. The Therapist, vocal part is a single staff with a treble clef. The Therapist, piano part is a grand staff with treble and bass clefs. Arrows indicate connections between the Patient's marks and the Therapist's notes.

Figure 12.63 Episode 11: bars 24–26

Figure 12.64 shows musical notation for three parts: Patient, Therapist, vocal, and Therapist, piano. The Patient part is a single staff with 'x' marks and vertical lines indicating rhythm. The Therapist, vocal part is a single staff with a treble clef. The Therapist, piano part is a grand staff with treble and bass clefs. Arrows indicate connections between the Patient's marks and the Therapist's notes.

Figure 12.64 Episode 11: bars 26–27

#### TRANSFORMATION AND SELF-DISCOVERY

In the following bars (31–33) the patient strengthens his focus on the long-drawn-out melody notes, setting his dotted triad motifs in analogy with the upbeat melodic quaver figure of the theme. His expressive quality and the tonal balance of the elements demonstrate an inner synchronization, which he relates to the melody (see Figure 12.65).

The melodic material, repeatedly modified and formed anew by the therapist responding to the patient, constitutes the basis of the musical relation. In bars 31–33

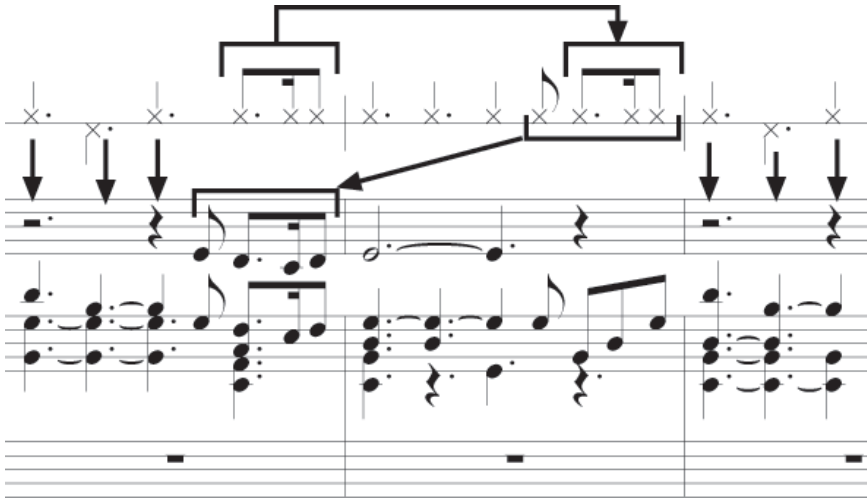


Figure 12.65 Episode 11: bars 31–33

the theme rings out in the two-line octave ( $h^1/h^2$ ), and the therapist takes up some of the melodic quaver figures in her vocal part.

The ascending bass figures appearing again in the therapist's part (bars 34–36) pick up a rhythmic motif played by the patient in bar 12 (see Figure 12.66). They run through the tonal range of two octaves ( $c/h^1$ ) and lead to the melody note  $g^1$ ,

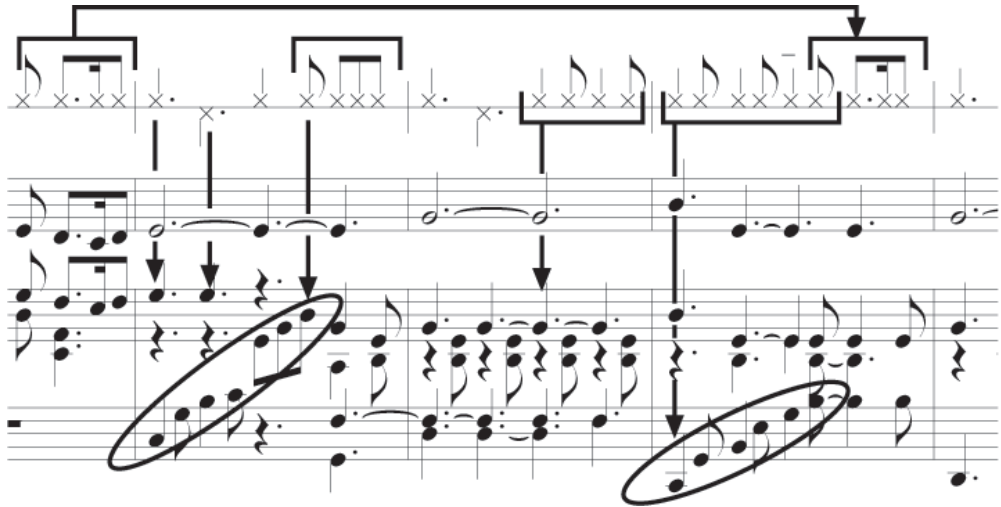


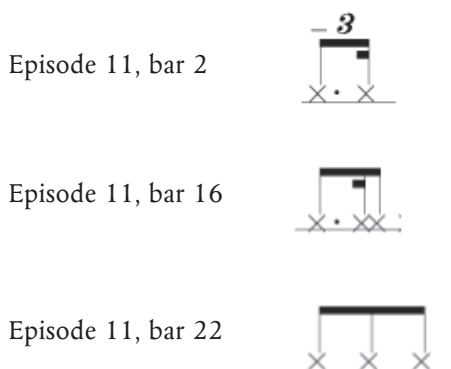
Figure 12.66 Episode 11: bars 34–36

which fills a whole bar (35). The middle part with its passing appoggiatura as accompaniment has a relaxing effect on the musical structure and the sound pattern.

The patient continues his mode of play with minor variations. The dotted crotchets in basic beat, the upbeat three-quaver group and the dotted triad group emerge as consistent elements. His reference to the ascending bass figure becomes apparent in bar 34; he continues it almost on the last beat. In bar 36 he takes up the rhythmic form of the bass figure and thus accentuates it even more.

In Episode 11, the patient first passes through various stages of orientation, search, determination and transformation, repeatedly alternating between these categories. In doing so, he experiences the discovery and sharing of melodic aspects (motif form, pitch direction, melodic forms of intervals, two-beat forms), which he is able to refer to and which help him to develop an integrative mode of play that ultimately leads to self-discovery and expression.

At the onset of the episode, the patient clearly needs time to find some form of inner security (bars 12–13). The therapist provides support here with short one- or two-measure melodic figures, which maintain their open quality in the process of the patient's virtually developing decisions (variable time structure, open harmony). The therapist introduces a more comprehensive melodic gestalt from bar 14 onwards, after the patient has intensified his inter-musical relation in expressing the internally absorbed metre. In the further course of the episode the therapist expands the melodic gestalt. An integrative part of this gestalt is the melodic–rhythmic motif of the three-quaver note group that developed out of the dotted quaver triplet in the patient's voice and alternates with the variable dotted version (see Figure 12.67).



*Figure 12.67 Episode 11: melodic-rhythmic motif*

These melodic elements help to create a close musical relation between patient and therapist. In addition to the fundament of the dotted crotchet note in basic beat, they constitute the 'safety elements' in the patient's music that he combines in a number of different ways during the episode and integrates effectively into his individual interpretation.

On the basis of the melodic improvisation, the patient is able to find a peaceful and clear mode of expression, uninterrupted by any impulsive rhythmic outbursts. He is part of the close network of melodic–rhythmic relationships, and with the discovery of his identity, contributes towards the coherence of the melodic improvisation. The open melodic quality with its major seventh, which does not imply an urgent resolution, is possibly of prime importance for sustaining the melodic relationship.

The therapist's personal comment on this episode was 'Development of confidence and trust. Experience of personal emotions. Both sides allow themselves to be supported.'

## **Process of musical integration and innovation (Episodes 12–16)**

### *Process of musical integration and innovation: Episode 12*

Episode 12 constitutes the onset of the second improvisation in the third session, immediately subsequent to a final turn of the first improvisation in joint play with the therapist (see Figure 12.68).

The sound in the third session is dominated by the temple blocks, which the patient decides to play with one stick. The five resonant bodies arranged horizontally on a support consist of hollow wooden globes with longitudinal slits, with audibly different pitches that defy any exact definition. In order to give an approximation of the patient's different pitches, we use two staff lines for the lower and higher notes (Figure 12.68).

Episode 12 is the start of a new development stage that represents a process of musical integration and innovation, and is defined by the categories of determination and transformation.

### **DETERMINATION**

The patient begins with a calm slow pace and develops his play from there. He selects an ascending rhythmic–tonal motif, which he repeats on the initial lower note. He expands this motif into a dotted variant, intensifies it dynamically, and concludes with an accentuated crotchet note. His clear musical statement becomes

The musical score is divided into two systems. The first system features the Patient (Temple blocks) on a single staff with a 6/8 time signature and a tempo marking of  $\bullet = 50$ . The Patient's part begins with a half note followed by a dotted half note, marked *mp*. The Therapist (Paino) part is shown on a grand staff (treble and bass clefs) with a 6/8 time signature, remaining silent in the first system. The second system shows the Patient's part continuing with a half note and a dotted half note, marked *p*. The Therapist's part enters with a series of chords in the bass range, marked *sempre stacc.* (sempre staccato).

Figure 12.68 Episode 12

apparent in his adherence to an inner pace, a selected measure (6/8) and his individual rhythmic and dynamic interpretation. He underlines the specific quality and two-time structure additionally in the deliberate use of the different tonal effects ranging from low to high.

Following the patient's metric performance, the therapist (bar 2) supports him with chords in the bass range (see Figure 12.69). They appear without a third as neutral seventh chords above the major A and in moderate staccato are used in imitation of the patient's voice.

#### TRANSFORMATION

Repeating his two-time mode (bars 3–4), the patient starts to reshape his musical material. At first he maintains his rhythmic–tonal basic motif, but he inverts it so that the onset of his two-time play this time has a high–low effect. Due to a double dot, he now shortens the expanded variation of bar 2, with one dot, but rounds it off with a crotchet note, as in bar 2. On the whole, he now concentrates on the tonal interpretation and frequently alternates between two pitches. The original motif,

The musical score is in 6/8 time. The top staff (treble clef) has a tempo marking of quarter note = 50. It begins with a half note on G4, followed by a dotted half note on A4, and then a half note on B4. The bottom staff (bass clef) has a half note on G3, followed by a dotted half note on A3, and then a half note on B3. The dynamics are marked *mp* (mezzo-piano) for the top staff and *p* (piano) for the bottom staff. An arrow points from the first measure of the top staff to the first measure of the bottom staff.

Figure 12.69 Episode 12: bars 1–2

when repeated (bar 3), appears as an inversion, and in varied continuation (bar 5) with an accentuated high note.

The therapist expands her measure with a melodic flourish in the form of a three-note group reaching out to the one-line octave (bar 3; Figure 12.70). This insertion may be interpreted as a reflection of the rhythmically expanded variation of the original motif (bar 2) in the patient's voice. She takes it up once more in bar 5.

The original motif initiated by the patient ensures the inner cohesion of his play; it also demonstrates form-building properties insofar as the patient always puts it at the beginning of his figures (see Figure 12.71).

Figure 12.72 illustrates the therapist's reference to the expanded dotted variation created by the patient. The patient demonstrates in this episode that he has found a clear mode of expression, which he is able to utter on his own accord and independent from the therapist. His inner-musical connection becomes apparent in the continuous measure which he relates to the time (6/8), the appropriate integration of the different pitches available to him into his rhythmic motifs and forms, and the calm performance of his emerging tonal interpretation, which incorporates the dynamics in a well-balanced manner. The two-time figures with slight variations produce an underlying four-time structure the inner coherence of which is ensured by the initiated rhythmic–tonal original motif.

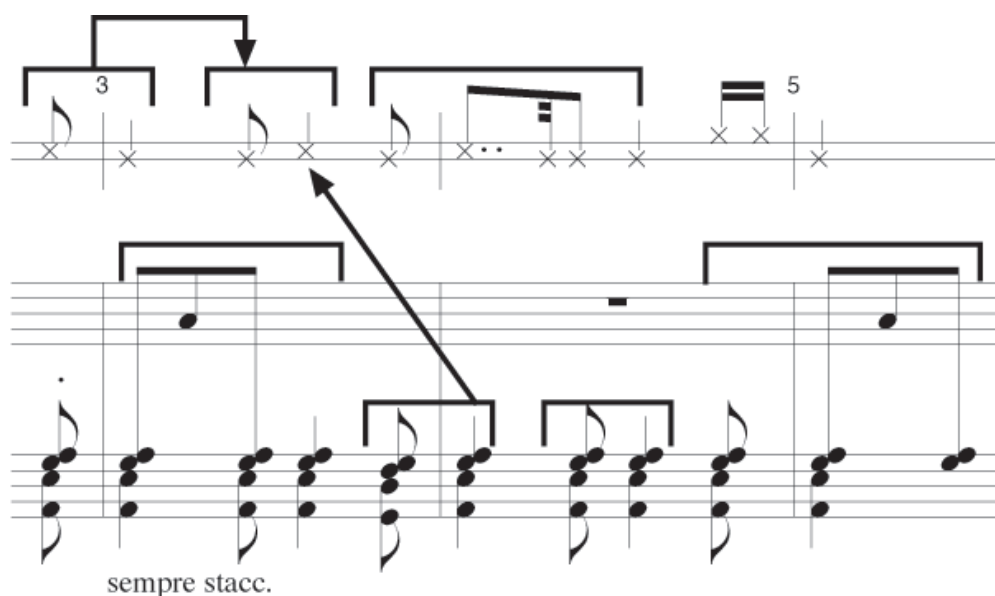


Figure 12.70 Episode 12: bars 3–4

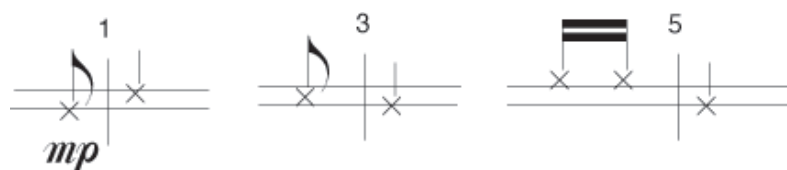


Figure 12.71 Episode 12: the original motif as form-building figure in bars 1, 3 and 5

In this episode we perceive the patient's inner integration at the moment of his musical creation. His previously imposing forceful activity now gives more room to a new expression, an expression of composure, self-possession, flexibility and good balance.

### *Process of musical integration and innovation: Episode 13*

Episode 13 belongs into the context of the second improvisation in the third session. It emerges in the further course of this improvisation, after the patient has initiated a dialogue (see Figure 12.73). The categories in this episode are determination, transformation and self-discovery.



Figure 12.72 Episode 12: bars 2–4

#### DETERMINATION

The determination category is evident in the patient's initiative for a deliberate choice of the dialogue as form. The musical content is a sound figure reminiscent of a triad (bar 1). The therapist responds to it immediately with longer sound intervals (major sixth, fourth) above the seventh chord in E-major. The patient responds to the therapist's figure in the same rhythmic modality but different inflection; with his repeated figure of a third he balances, in dynamic graduation, the therapist's figure with its outstanding volume (see Figure 12.74).

#### DETERMINATION AND TRANSFORMATION

The therapist indicates in bar 4 that she takes up the patient's play in an imitative fashion with her alternating note figure ( $h^2-a^2$ ) that appears in melodic inversion to the third (bar 3). The descending melodic line resolves in a triad in A-minor and leaves room for a continuation of the dialogue (see Figure 12.75). The patient introduces a contrasting complement to the therapist's alternating note figure into the same bar. He reinforces the therapist's descending tendency and stresses it even more with the highest and lowest notes. This tonal 'exposition' of the pitch direction with the quarter movement fading out in *ritardando*, and the patient's early intervention in the dialogue, both suggest that he strives for a general change in expression, which however does not become evident prior to bar 13.

1

Patient (Temple blocks)

Therapist (Piano)

4

P.

Th.

7

P.

Th.

10

P.

Th.

*mf*

*mp*

*mp*

*rit.*

*pp*

The musical score is divided into four systems, each representing a measure of the piece. The Patient part is written on a single staff with 'x' marks indicating the placement of temple blocks. The Therapist part is written on a grand staff (treble and bass clefs). The time signature starts in 3/4, changes to 6/8 at measure 2, and returns to 3/4 at measure 4. The Patient part begins with a *mf* dynamic and a *mp* dynamic. The Therapist part begins with a *mp* dynamic. The Patient part includes a *rit.* marking at measure 3. The Therapist part includes a *pp* marking at measure 4.

Figure 12.73 Episode 13

continued on next page

13

P.

Th.

rit.

*p*

cresc.

accel.

*f*

8<sup>va</sup>

16

P.

Th.

stretto

ritard.

*pp*

*f*

8<sup>va</sup>

19

P.

Th.

2

Figure 12.73 Episode 13 continued

Figure 12.74 Episode 13: bars 1–3

Figure 12.75 Episode 13: bars 4–6

The therapist's response to this intervention may be described as recitative-like. She slowly carries on the fading quarter movement on the note  $e^2$  (above E-major) in the articulation of a speaking note. The patient relates to this 'inflexion' (bar 6) and takes up the recitative mode (reduction to one pitch) together with the corresponding articulation. His imitative reaction reveals not only his inner-musical reference to structuring principles, but also his relation to the therapist. He does not follow his own impulse, which might have caused a basic change, but rather decides to continue the dialogue in the form of an assimilating, peaceful exchange of musical figures.

## TRANSFORMATION

This process of a dialogue emerging in the described manner continues over the subsequent bars within the transformation category. In bar 9 the therapist repeats her recitative figure from bar 5, which is then imitated by the patient (see Figure 12.76).

The musical score for Figure 12.76 is in 6/4 time. It consists of two staves: 'P.' (Patient) and 'Th.' (Therapist). The Therapist's part (Th.) is written in treble and bass clef. In bar 9, the Therapist plays a recitative figure consisting of a series of eighth notes in the treble clef and a single note in the bass clef. In bar 10, the Therapist repeats this figure. The Patient's part (P.) is written in a single staff. In bar 9, the Patient plays a recitative figure consisting of a series of eighth notes. In bar 10, the Patient repeats this figure. Arrows indicate the relationship between the two parts: 'see bar 5' points to the Therapist's part in bar 9, and 'see bar 6' points to the Patient's part in bar 10.

Figure 12.76 Episode 13: bars 9–10

The expansion of the tonal figure (forth, fifth) in the harmonic context of A-minor (bar 11) is imitated by the patient accordingly in three different pitches (Figure 12.77). Again, he intervenes early in the therapist's part, and his dialogue-style response fades out in decrescendo (towards *pp*). His early intervention has complementary features and in part underlines the two-time structure of this musical form.

Bar 13 constitutes a turning-point within this episode (see Figure 12.78), leading to something new that eventually ends in the category of self-discovery. This was suggested in bar 11 with the patient's early intervention in the therapist's part and did not only terminate the dialogue form but also underlined the dominance of the intruding voice. In bar 13 the patient announces his intention to provoke a change. It is possible that the ascending octave ( $d^2/d^3$ ) in connection with the anticipated descending pitch direction supports his changing over to simultaneous music-making. Obviously, the highest note  $d^2$  serves as his 'preparatory beat' for his descending melody line with *appoggiatura*. An interesting point is that he starts the *appoggiatura* notes from below so that they form a contrast to the descending pitch direction.



Figure 12.77 Episode 13: bars 11–12

Figure 12.78 Episode 13: bars 13–14

Both patient and therapist express this 'transitional situation' via their jointly played decrescendo and ritardando. The impression of vagueness of this section is also underlined with regard to harmony (diminished triad on *gis*<sup>1</sup>) and a tension that is built up urgently requiring resolution. In bar 14, the therapist again starts softly (*p*)

with the octave ( $e^1$ ) in the ambit of three octaves, and thus initiates a transitional situation. The octave  $e^1$  in this context has a clearly dominant function.

The patient alternates his appoggiatura notes (this time from above) with the therapist and joins in the gradually developing intensification (tempo, volume).

Bars 16 and 17 show that at the highest note of the intensification the patient accelerates more at first (*stretto*) and thus breaks away from the therapist, but in the subsequent *ritardando* (bar 17) deliberately lets the previous intensification fade into decrescendo simultaneously with the therapist and guides it towards the rest, which forms a caesura (see Figure 12.79). Its significance may be seen in the inner clarification that enables the patient to focus on himself in a new mode of expression.

Figure 12.79 Episode 13: bars 16–17

#### DETERMINATION AND SELF-DISCOVERY

The internal process of clarification produces the category of determination. In this case it leads him towards self-discovery, as it is obvious for him how to proceed; i.e. with which mode of expression he wishes to define himself. This consists in a melodic figure with alternating note motifs (a major mediant) which he leads downwards (see Figure 12.80). He thereby defines the measure (4/4), which emerges here clearly for the first time, and also the brisk pace and the strong intonation, articulating each note with precision.

Given that he repeats his melodic figure several times, the therapist may conclude that the patient not only determines his new mode of expression for

Figure 12.80 Episode 13: bars 18–19

himself but also wants to make it clear to her. He dominates the playing with his new melodic figure and defines the expression in the further course of the improvisation.

The therapist accompanies the clear melodic figure with appoggiatura octaves on the basic tone ( $a^1$ ) in the ambit of four octaves with staccato articulation.

This episode reveals the process within a relationship that eventually leads the patient to self-discovery. The patient himself initiates this process of discovering, evoking both dialogue and simultaneous music-making and using it for his own purpose. The asymmetries emerging in the dialogue section are due to repeated changes in time and metre. Both are ambivalent and of no importance to the inter-musical relationship, which has its focus on the tonal–melodic figures, exchanged freely and imitated by both patient and therapist. A comparison with free improvisation comes to mind here, which allows the musician to imitate a phrase, a figure or a motif in many different ways; in contrary motion, inversion, augmentation or diminution. Some of these musical principles are seen in this and the previous episode (Episode 12 inversion, Episode 13 contrary motion). The significance of the imitation, however, becomes apparent mainly in the context of the intra- and inter-musical relationship. In the process of imitation, patient and therapist are absolutely focussed on each other, they follow each other's steps, and each takes up the characteristics of the other in their own music-making. This process of imitating, of adjusting and reflecting oneself contains the potential for the creation of new and



individual patterns of expression. This is where we should remember the evolving change from imitation to assimilation to innovation, which many musicians – in particular in jazz – perceive as significant in their personal development.

The patient's early intervention in connection with his dynamic interpretation (*decrescendo*) (bar 12) suggests that he has internally prepared himself for change. In bar 13 this attitude brings him to a transition passage jointly played with the therapist (assimilation). Within this open phase (bars 13–17), a close note-by-note relationship is built up which the patient turns into a simultaneous relation via the *stretto* (bar 16) and eventually guides towards the rest. The successive play first turns into separate, and then joint music-making. The jointly sustained rest constitutes the end of this open transition phase and at the same time the beginning of something new. The patient literally takes this new phase into his own hands and reveals his decision in favour of clarity, unmistakability, unambiguity, openness and decisiveness in the form of a melodic figure (innovation). Clarity emerges not only in his inner musical relation but also in his relationship with the therapist that is defined now by his guidance and control of the further course of the improvisation.

In her personal notes, the therapist comments on this part as follows: 'I feel that in bar 14 he is still not prepared to follow his inner voice – perhaps he has not perceived it so far, has not felt his theme. He must first experience himself in an intensification, totally, and develop a feeling for relation before he can shape the further course confidently and independently.'

### *Process of musical integration and innovation: Episode 14*

Episode 14 developed in the further course of the second improvisation of the third session. It starts after the patient has introduced a new rhythmic movement (see Figure 12.81). The categories of this episode are determination, transformation and self-discovery.

#### DETERMINATION

The determination category may be demonstrated with two examples. At the very beginning of the episode, the patient returns to his characteristic *appoggiatura* motif and underlines it in a striking manner with a tonal differentiation on the first and third beat. He combines the ascending pitch direction with clarity in marking the metre, in articulation and the chosen vigorous expressivity.

The therapist supports the patient with a bass accompaniment in even crotchet notes (see Figure 12.82), alternating between the keynote and the fifth (F-major). In her upper voice, the *appoggiatura* motif appears in connection with the triad in

$\bullet = 120$  Moderato

Patient (Temple blocks)

Therapist (Piano)

3

P.

Th.

6

P.

Th.

9

P.

Th.

Figure 12.81 Episode 14

♩ = 120 Moderato

Figure 12.82 Episode 14: bar 1

F-major. However, being guided downwards to the bass voice, when taking up the same mode of articulation it appears in inversion of the patient's voice.

The following two bars show that the patient's initiative concerning the interpretative ideas of his appoggiatura motif also addresses his relation with the therapist (see Figure 12.83). The harmonic shift towards E-major in the therapist's voice induces him to modify his play (change to bodies of higher resonance) and to

Figure 12.83 Episode 14: bars 3–4

actively participate in the phrasing resulting from this harmonic constellation (crotchet rest) by making the caesura 'audible'. The musical unit comprises three bars.

#### TRANSFORMATION

In the following example (bars 6–8), the transformation category reveals the patient's skill in using his appoggiatura motif in such a way that it forms a new combination. He achieves this with a change in the metre and a modification of his rhythmic gestalt. In bar 6 he stresses the third beat as a basic beat crotchet and thus advances his appoggiatura motif to the fourth beat. At the same time he varies and expands his rhythm so that a new rhythmic–tonal gestalt emerges. This musical unit consists of four bars (see Figure 12.84).

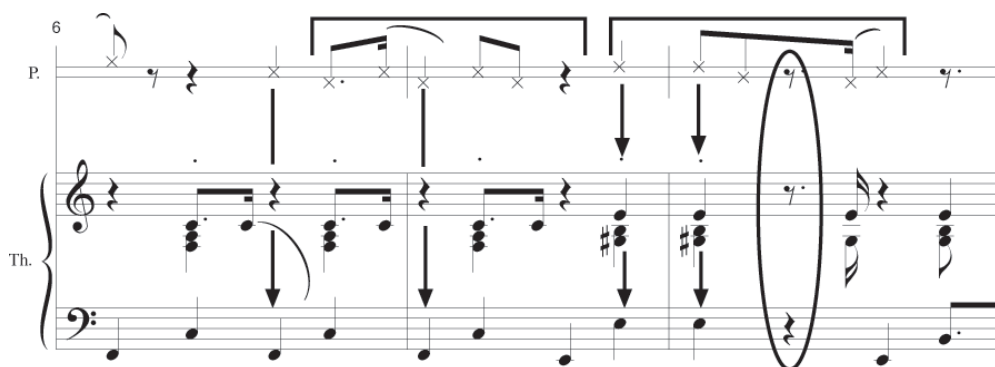


Figure 12.84 Episode 14: bars 6–8

#### SELF-DISCOVERY

The patient returns to his mode of expression in the first bars and again experiences himself in his initial movement, accentuating the first and third beat and shaping the music with his tonal changes in accordance with the three-time mode (bar 11). The naturalness of his performance suggests that he has gained more confidence to find his individual expression in his relationship with the therapist (see Figure 12.85).

Episode 14 demonstrates how the patient employs his determination positively for a transformation of the musical material and is able to establish his self-discovery in the confirmation of his original mode of expression.

The underlying element here is the appoggiatura motif, which has emerged as the patient's characteristic element in the course of the therapy. Depending on the

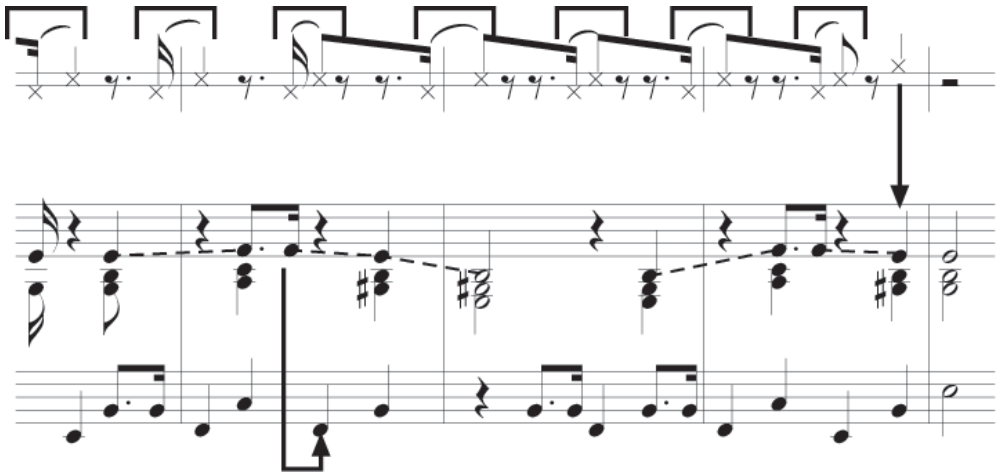


Figure 12.85 Episode 14: bars 9–11

context, its appearance differed from episode to episode (Figure 12.86). While his early intervention is sometimes isolated with a vigorous and exaggerated 'short–long effect', his subsequent appearance is linked more closely to his own expression which corresponds to the meaning of the improvised music in each instance. Here, his appoggiatura motifs seem clearer, more articulate, and indicate their significance when they become integrated in the context of music and theme.







In Episode 14 the patient places his appoggiatura motif into a new musical context. This opportunity for musical transformation has also affected his inner life. He is no longer under 'pressure' to be active but rather performs in a calm and collected, balanced manner and deliberately shapes articulation and form.

The therapist's personal notes state: 'The patient appears to have found an inner balance. He has recourse to something which suggests more inner strength. My impression is that of consistence and stability.'

### *Process of musical integration and innovation: Episode 15*

Episode 15 is part of the second improvisation in the third session. Between its onset and the end of the previous Episode 14 there is a short section in vigorous forte which continues to employ the characteristic appoggiatura motif from Episode 14 (see Figure 12.87).

The categories of determination, transformation and self-discovery again succeed one another in this episode. Towards the end, we have a superimposition of transformation and self-discovery.

Ep. 3, bar 25	
Ep. 4, bar 5	
Ep. 6, bar 2	
Ep. 9, bars 1–2	
Ep. 13, bar 13	
Ep. 14, bar 1–2	

*Figure 12.86 Episode 14: various occurrences of the appoggiatura motif*

#### DETERMINATION

In the first example (bars 1–2), the patient indicates his determination with his sharply dotted appoggiatura motifs in fortissimo simultaneously with the therapist (see Figure 12.88). We may assume that the therapist's triadic arpeggios (E-major), descending in octaves and announcing the end of the previous energetic part, have induced the patient to change over to a crotchet movement.

**Figure 12.87 Episode 15**

**Tempo and Dynamics:**  $\bullet = 110$  Moderato. Dynamics include *ff* (fortissimo), *ritard.* (ritardando), and *p* (piano).

**Instrumentation:** Patient (Temple blocks) and Therapist (Piano).

**Structure:** The score is divided into three systems, each starting with a measure number (4, 7, 11) and a tempo change.

- System 1 (Measures 4-6):** Tempo  $\bullet = 60$  Larghetto. The Patient part consists of rhythmic patterns marked with 'x'. The Therapist part features a melodic line in the right hand and a supporting bass line in the left hand.
- System 2 (Measures 7-10):** Tempo  $\bullet = 70$ . The Patient part continues with rhythmic patterns. The Therapist part includes a *ritard.* marking and a *pp* (pianissimo) dynamic.
- System 3 (Measures 11-14):** The Patient part includes a *ritard.* marking. The Therapist part concludes with a final melodic phrase in the right hand and a sustained bass line in the left hand, marked with a fermata and a *2* (second ending) symbol.

Figure 12.87 Episode 15

♩ = 110 Moderato

P.

Th.

*ff*

*ff*

Figure 12.88 Episode 15: bars 1–2

The second example (bars 2–3) of this category follows immediately. The descending triadic arpeggios in the therapist's voice now fade out in the bass register on the notes G-sharp and E in *ritardando* (see Figure 12.89). The repetitive element, consisting of the briskly begun octave sounds and fading dynamics, makes the transition to a new section with varied expressivity particularly audible.

*ritard.*

*ritard.*

*p*

Figure 12.89 Episode 15: bars 2–3



The patient decides to change to a new mode of expression, because he concentrates his play on a quarter movement, transferred to the deeper resonances in analogy with the therapist's tonal register and pitch direction, in *ritardando* and *decrescendo*.

In the last example of the category determination (bars 4–5), the patient takes up the therapist's offer of a dialogue and confines himself to one single element, the interpretation of the pitch structure. In a calm *larghetto* pace he imitates the therapist's movement up and down with a soft, calm and subtle expression. He traces the lines of her diastematic notation, so to speak (see Figure 12.90).

Figure 12.90 shows a musical score for two staves, P. (Patient) and Th. (Therapist). The tempo is marked 'Larghetto' with a quarter note equal to 60 beats. The P. staff shows a sequence of notes with 'x' marks above them, indicating specific pitch points. The Th. staff shows a corresponding sequence of notes, with arrows pointing from the P. staff to the Th. staff, indicating the patient's imitation of the therapist's pitch structure. The Th. staff also includes a diastematic notation (a line with 'x' marks) that the patient is tracing.

Figure 12.90 Episode 15: bars 4–5

The therapist selects the patient's *appoggiatura* motif as the basis for the musical dialogue. It appears rhythmically augmented by the slow pace, and she uses it to shape the pitch structure in the bass register. Second, fourth and fifth intervals are melodically shaped: ascending from E to H, again descending from the tritone (F) to E, and ascending once more to H. The tonal reduction to octaves underlines even more clearly the element of pitch direction.

#### TRANSFORMATION

This imitatory exchange of pitch elements reaching over approximately four bars in subtle sequence undergoes a turn in bar 7, where the therapist allows the melodically shaped section to fade out on the octave sound E. At the same time she uses the same

octave sound to create an upbeat ostinato in very soft dynamics that gives the patient room for other musical utterances.

The patient introduces a new expressive element in the form of a melodic figure with a 'speaking' character. The accentuation of the tonal repetitions with the appended appoggiatura motif, which has now undergone a melodic change, as well as the mode of play independent of beat, which keeps the length of phases variable, combine to underline the rhetoric element of this music.

The therapist responds to this new expressive element in the patient's voice. She takes up the melodic motif in her upper part with the changeover to the seventh chord superimposed with a third (see Figure 12.91).

The musical score for Figure 12.91 shows two staves: Patient (P.) and Therapist (Th.). The time signature is 3/4. The Patient's part begins in bar 7 with a melodic figure marked 'p' (piano). The Therapist's part begins in bar 8 with a melodic motif marked 'ritard.' (ritardando) and 'pp' (pianissimo). The score includes a tempo marking of 70 bpm and a dynamic marking of 'pp' at the bottom.

Figure 12.91 Episode 15: bars 7–9

#### TRANSFORMATION AND SELF-DISCOVERY

The last example again reveals the close transition from one category to the next. In the process of inner transformation, the patient experiences himself in a still unfamiliar mode of expression that allows him to be more aware of his self as something new. In bar 10 the patient returns to his melodic figure from bar 9 and this time guides it upwards, as the beginning of a melodic line developing from then on which extends to bar 12. These bars reveal clearly not only his inner musical relation but also that with the therapist.

The therapist sustains her ostinato form as harmonic accompaniment. She responds to the patient's ascending melodic line (bar 10) with an alternating harmonic timbre (triad to E). Above this ostinato harmony, the patient pursues his

melodic line in an evenly descending alternating note motif in *ritardando* that ends in bar 12 with a crotchet note.

The therapist continues her playing accordingly with the patient's crotchet note, guiding her tonal figure (bar 12) upwards with a major third ( $c^1/e^1$ ) and over the repeated  $e^1$  back to  $c^1$ . Again the last note ( $c^1$ ) is sustained, which as a tonal link supports the patient's next intervention.

The patient pursues the therapist's tonal figure further in free imitation, also accentuating the rhetoric element of this complementary-dialogue character with his *ritardando* repetitions (see Figure 12.92).

Figure 12.92 Episode 15: bars 10–14

Episode 15 reveals an intensification of the process of transformation – which started in the previous episode – and its transition, or rather its turn towards the category of self-discovery. This happens in the course of two sections, whereby the impulse for the formation of the first section (bars 4–7) first comes from the therapist, while the second part (bars 8–14) is dominated by the patient.

In the first section, the patient's *appoggiatura* motif appears in a completely different mode. In slow *larghetto*, it serves as the substance of his inner expression on which he can communicate with the therapist in dialogue. This is how the motif thus exposed gains in significance; the emphasized pitch interpretation provides a melodious quality and thus meets the patient's need to experience himself in a soft, subtle, free and expressive manner.

On the basis of this experience in expression, the patient expands his previous patterns by more comprehensive melodic figures that integrate the *appoggiatura* motif (bars 8–14). He again feels the need to listen to his inner sensations and to articulate them. His current, specific manner of expression, which he relates to the musical context (i.e. to the therapist) in free imitation (inversion, augmentation

expansion), seems to be important to him; this is apparent in his diligent, careful and subtly shaded performance. His playing is sustained by his inner musical contact. He is able to interpret freely and spontaneously, unrestricted by a specific measure, and to follow his inner need of expression. Once more we can observe that a more conscious 'self' is revealed which increasingly gains confidence in its own feelings and the therapy situation.

### *Process of musical integration and innovation: Episode 16*

Episode 16 is the last example of the group of five episodes emerging from the cluster analysis of the grid elements. Consequently it is also part of the last phase of the therapy where the patient has entered into a process of musical integration and innovation.

Episode 16 is from the third session and starts shortly after the beginning of the fourth improvisation. The onset of the fourth improvisation initiated by the patient is very open in character, with a concentration on the sound element (tremolo, dynamics, rubato) – see Figure 12.93.

The categories of determination, transformation and self-discovery emerge in the course of this episode, preceded by a short example of the orientation category.

#### ORIENTATION

The first example (bars 1–2) shows the patient's rhythmic–tonal orientation when he includes the various resonant bodies, with a remarkable interpretation in the form of reticent dynamics and the use of the musical inversion of the appoggiatura motif.

The therapist supports the patient with a metric–tonal background in alla-breve time. The harmonies are kept very open, with the inclusion of the major seventh chord on D, with a fifth in bass. A consistent quaver metre unfolds in the upper voice which simultaneously stresses the melodic intervals of the fourth and the major sixth (see Figure 12.94). Legato and the use of the pedal intensify the iridescent tonal background.

#### DETERMINATION

Bars 4 and 5 illustrate that the patient has chosen a particular mode of play, returning deliberately to his appoggiatura motif and differing from the therapist's consistent quaver movement by a stress on the third beat (see Figure 12.95). He again modifies his play by way of inversion. The therapist's voice continues the characteristic element of the accompanying quavers, complemented in bar 5 with an additional upper voice, which stresses the note a<sup>2</sup>.

The musical score for Episode 16 is presented in six systems, each consisting of a Patient (Temple blocks) part and a Therapist (Piano) part. The Patient part is marked with *ppp* and the Therapist part with *pp*. The score includes various musical notations such as notes, rests, and dynamic markings.

**System 1:** Patient (Temple blocks) part starts with a *ppp* dynamic. The Therapist (Piano) part starts with a *pp* dynamic. The Patient part has a measure with a rest and a note marked *ppp*. The Therapist part has a measure with a rest and a note marked *pp*.

**System 2:** Patient (Temple blocks) part starts with a *p* dynamic. The Therapist (Piano) part starts with a *mp* dynamic. The Patient part has a measure with a rest and a note marked *p*. The Therapist part has a measure with a rest and a note marked *mp*.

**System 3:** Patient (Temple blocks) part starts with a *mf* dynamic. The Therapist (Piano) part starts with a *mf* dynamic. The Patient part has a measure with a rest and a note marked *mf*. The Therapist part has a measure with a rest and a note marked *mf*.

**System 4:** Patient (Temple blocks) part starts with a *mf* dynamic. The Therapist (Piano) part starts with a *mf* dynamic. The Patient part has a measure with a rest and a note marked *mf*. The Therapist part has a measure with a rest and a note marked *mf*.

**System 5:** Patient (Temple blocks) part starts with a *mf* dynamic. The Therapist (Piano) part starts with a *mf* dynamic. The Patient part has a measure with a rest and a note marked *mf*. The Therapist part has a measure with a rest and a note marked *mf*.

**System 6:** Patient (Temple blocks) part starts with a *mf* dynamic. The Therapist (Piano) part starts with a *mf* dynamic. The Patient part has a measure with a rest and a note marked *mf*. The Therapist part has a measure with a rest and a note marked *mf*.

Figure 12.93 Episode 16

Figure 12.94 Episode 16: bars 1–2

Figure 12.95 Episode 16: bars 4–5

#### TRANSFORMATION

The inclusion of the melodic upper voice in conjunction with the harmonic line produces larger musical contexts. These suggest a combination of musical elements in the therapist's voice, and in addition are of relevance for the developments emerging in the patient's voice in the transformation category.

In bars 7 and 8 the patient refers to the therapist's melody notes exposed in the high register, which he complements melodically with his appoggiatura motif,

expanding his motif by one quaver (see Figure 12.96). In the therapist's voice, the original accompanying quavers are turned into repetitive afternotes ringing out above the ostinato bass note d<sup>1</sup>.

Figure 12.96 Episode 16: bars 7–8

The patient maintains his mode of play over the subsequent bars in accordance with the repetitive structure and only varies the sound component. Bar 12 reveals that he anticipates the form and in response again varies his melodic motif in order to round off the previous section (bars 5–12). This final turn descends and ends on the lowest note. We can discover another reference to the pitch direction, as his melodic final turn, ascending at first, is his inverse reaction to the therapist's clearly descending melodic fifth (see Figure 12.97).

#### TRANSFORMATION AND SELF-DISCOVERY

The formal structure of the improvisation, which is essential for the manifestation of both categories, is repeated in a similar way up to the end of this episode. In the following example (Figure 12.98, bars 13–16), the 'falling' melodic fifth (cis<sup>3</sup>–fis<sup>2</sup>) dominates the therapist's part, always accentuated and always on the first beat. The bass accompaniment, also in fifths, appears in a contrary motion. In contrast to the therapist, the patient's melodic motif turns out to be upbeat. He imitates and responds to the therapist's melodic voice; he repeats with the appropriate pitch direction, introduces sequences, articulates and concludes the four-bar unit in bar 16.



Figure 12.97 Episode 16: bar 12

Figure 12.98 Episode 16: bars 13–16

In bar 17 the patient assumes dominance (see Figure 12.99). Simultaneous to the therapist, he stresses the first beat for the first time (bar accent). In general, he changes his melodic motif into a four-time unit, and the quaver rests also suggest the ‘embedded’ appoggiatura motif. With his continuously flowing quaver movement (reminding of the quaver accompaniment of the first bars) he produces a wave-like effect that leads to the end of this episode in a balanced manner. The patient performs the end with greater emphasis; accentuated by the rest, he carefully plays



The musical score for Figure 12.99, Episode 16, bars 17–20, consists of two staves. The top staff is labeled 'P.' (Piano) and the bottom staff is labeled 'Th.' (Therapist). The Piano part shows a series of notes with 'x' marks above them, and a circled note with a '7' inside. The Therapist part shows a series of notes with a '8va.' marking. The score includes dynamic markings like 'mp' and a fermata over the final note.

Figure 12.99 Episode 16: bars 17–20

out the final turn in dynamic–agodic mode. We recognize his appoggiatura motif in the final turn; here it functions as a conclusion.

The patient reveals his ability to establish an inner- and inter-musical relationship within a short time in this episode. Within a few bars, he finds orientation and organization in the open tonal tapestry provided by the therapist. His soft playing may be seen as an indication of utmost attention. His individual interpretation shows consistence and makes musical sense. Here, the emphasis is again on the elements of sound, pitch and musical–melodic motif, which he is able to vary, transform and change playfully in many different ways so that these are given new significance in the course of the improvisation. This change in significance is most apparent in his appoggiatura motif, which has turned from a primarily rhythmic motif into a melodic motif and finally becomes a comprehensive melodic figure. The manner in which the patient uses his melodic motifs in the interactive music-making with the therapist demonstrates that he employs them as formative elements as well. Thus, he experiences himself in his present expressivity not only as part of the close network of relations and dependences (on himself and the therapist) but as a whole, and perceives elements of a higher order producing cohesion and influencing the form of the joint music. In this manner, the patient has succeeded in creating space for his own expressivity.

The struggle for clarity is a central point in the patient's play that intensified over the last episodes (12–16). To achieve this, he had to limit himself, thereby giving himself the opportunity to perceive his self in time more consciously; that is, to listen to himself in the moment of being. The observation and gradual shaping of his creative abilities in relation to the therapist have encouraged his self-esteem, confidence, personal integrity and autonomy.

The therapist recorded under her personal comments: 'The patient presents himself, what he plays and how he plays, with more confidence. My impression is one of more inner balance and equanimity, also of a sense of identity.'

Analysing the general aspects of form and expressivity in detail, we find that this study again demonstrates that dynamic form emerges in the context of clinical improvisation and is closely connected with the emotional content. The quality of this form mainly results from its psychological function; to communicate, to test one's limits, to explore one's self, also in relation to another person (therapist), to utter, accept or refuse something, to hold one's own, to deny, to hide, to leave decisions to another person or instead to try something new and to have self-confidence.

## Relation between Episodes and the ‘Farewell Melody’

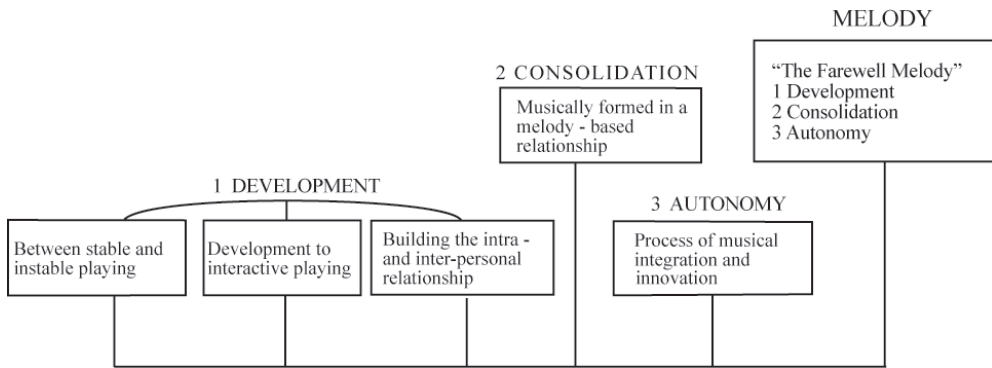
This chapter addresses the relation existing between the episodes and the melody of the last session. Again, an effort is made to underline the process character in the course of the episodes that appear as structured interactions in time.

In Chapter 12, the musical elements relevant for the categories of the constructs have been revealed and related to the categories of the episodes. Musical patterns have been defined as to their significance. Numerous musical examples have illustrated the categories search, orientation, decision, transformation and self-discovery.

### **Development of categories of episodes**

First we consider the general form of the therapy process developing out of the categories of elements (episodes). As in ‘A Walk through Paris’, we present the process graphically (see Figure 13.1).

This graphic displays the course of five periods that we know from Figure 11.3. In addition, the grid analysis suggested that Episode 1 and the clusters of Episodes 2–5 and 6–10 are correlated on a higher level of abstraction and thus suggest common features. The clusters of Episodes 15–16 are different. Both groups (Group 1: Ep.1, Ep. 2–5, Ep. 2–4; and Group 2: Ep. 11) are separated by one episode that also serves as a transition. This is Episode 11, which stands out from the therapy course. On this superior level, we may thus define three phases that on the ‘map’ are entitled DEVELOPMENT, CONSOLIDATION and AUTONOMY. There is a longer phase of development, followed by a short one of consolidation, and concluded by a longer phase of autonomy.



*Figure 13.1 Presentation of the overall form of the course of therapy according to the categories of the episodes separated into three phases (the final phase is the completed melody)*

If we take a close look at the episodes themselves, we see a clearly discernible development within the superior form of the three phases.

### *Development*

The patient first vacillates between an instable and a stable type of playing, trying to organize and assert himself. From this first phase, consisting only of Episode 1, he changes over to a second phase (Episodes 2–5), which is characterized by an initial tentative search for the joint play and by his ambivalence regarding variable and invariable, or steady, musical factors. The musical encounter is then expanded by the elements of articulation, sound and melody, and he passes on to the third phase (Episodes 6–10) where he establishes the intra- and inter-personal relationship. In both constellations, this is mainly defined by a process of obtaining clarity, expressed in the patient's play by contrasting polarities like formed–unformed, indecisive–decisive, unbalanced–balanced, and by his effort to sustain the metric structure. These first three periods are interconnected by a continuously expanding search for musical expression and therefore belong to the superior first phase entitled 'development'.

### *Consolidation*

The fourth period (Episode 11) stands out through the melodically sustained relation. Its significance derives from the consolidation of the relation on a new level of expression, sustained by a quiet, expressive melody. This 'assured relation' simultaneously endows the patient's playing with a creative activity that manifests itself

in numerous reminiscences, reflections and the beginning of more comprehensive forms. This period – the second superior phase of 'consolidation' – is that which enables the patient to proceed to the last period in his development (Episodes 12–16), to the process of integration and innovation. The integration of musical elements (suggested motif) gives the patient's play a stronger inner balance and equilibrium. Alteration and transformation are closely related to the musical context. Expression and form combine in a consistent musical performance that focuses on tonal, motif-related or melodic and dynamic factors.

### *Autonomy*

The patient is not only more self-confident but also in a position to answer for himself and his performance, which he initiates and carries out in an innovatory manner (Episodes 12, 13, 16). He demonstrates his identity with his music and his various modes of expression. This fifth period coincides with the last superior phase of 'autonomy'.

## **Development of the categories of constructs**

The next issue to be addressed is how the patient passed on from one episode to another, or how he was able to change over from one development phase to the next. For this, it is appropriate to refer to those categories of constructs that formed the relevant categories in musical analysis. Once again, a graphic description may serve to illustrate the categories of constructs in relation to the therapy process following the categories of episodes (see Figure 13.2).

The categories orientation and search appear in almost all stages; this suggests that before a patient may enter into each new phase he must find new orientation and look for an appropriate mode of expression. As we know, both categories appear in different constellations; e.g. orientation/search or search/orientation. In the subsequent therapy process, however, their significance changes; they separate and form new combinations with other categories. This is obvious in the second and third period where search combines with decisiveness, orientation combines with decisiveness and also with transformation.

In the second development period, search and orientation guide him towards decisiveness. This category is relevant for the whole therapy process as it gives the patient access to transformation, which ultimately allows him to achieve self-discovery. The category decisiveness may be considered as a patient's experimental field where he develops the activity and initiative that he then employs to come to a decision.

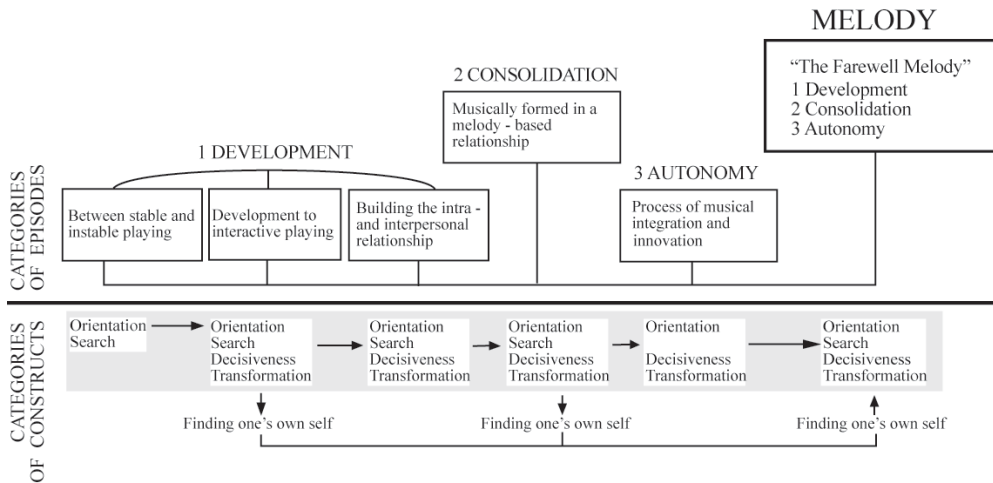


Figure 13.2 Presentation of the overall form of the course of therapy according to the categories of the episodes and the categories of the constructs as they relate to the episodes

Comparing the categories, we find that the patient more or less passes through the same cycle of categories each time. This repeated process of passing through and coping with all categories guides him through the phases of consolidation and autonomy towards his own melody, which as the 'Farewell Melody' finally comprises all the categories.

### *Significance of the category 'self-discovery'*

The question now arises as to why in the third stage the patient did not discover his self. The answer requires a closer look at the way in which he found his self in the second stage. This emerges at the end of the fifth episode with the significance of approaching the conscious 'self'; it becomes audible in the deliberate integration and concentration on one melody note which the patient prolongs over time in combination with the darker drum sound (longer resonance). He thus gives more room to the melodic element, and at the same time, he creates more room for himself to perceive his own, inner resonance and to find a more differentiated expression, which takes the shape of a peaceful conclusion, very subtle and soft and fading away.

The therapeutic dynamics that comprised the interaction between patient and therapist developed, and concluded, briskly. This is probably why the category self-discovery does not form part of the third development stage. The patient found his self after a relatively short period without, however, being able to make full use of it at that time. After this rapid development, the third stage begins with a short phase

of regression, where the patient again has to find access to his self (Episodes 6, 7). Consequently, the whole third period (Episodes 6–10) may be seen as a phase for building up intra- and inter-personal relations, mainly with the musical elements of metre, rhythm, sound, dynamic range and articulation and with a focus on exchanging common patterns of interaction. This phase leaves no room for self-discovery.

In the two subsequent development periods characterizing the phases of consolidation and autonomy, the patient once again passes through the cycle of categories and reaches the state of self-discovery in both instances. Self-discovery here helps to find one's identity and is therefore more significant for therapy. In the consolidation phase (Episode 11), this category is evident in the quality of his expression and the balance of his playful elements which suggest an inner synchronization achieved with the help of his relationship to melody. In the last phase of autonomy, the patient is able to establish his self-discovery by repeating and confirming his original modes of expression (Episodes 13–16). This repeated process of finding one's identity is characterized by increased confidence and a matter-of-factness in performing that permitted the patient to find an inner harmony and to maintain it in relation to the therapist. He is capable of defining himself more clearly in the therapeutic context. On this basis, he was able to generate his personal melody, in which he passed through the categories of search, orientation, decisiveness and transformation and once more regained his identity.

### *Factors of melody generation in this study*

This brings us back to the initial question of this study, our quest for the sources of melody generation. What we have seen so far in this second study is that:

- The three phases of development, consolidation and autonomy stand for the 'stages' the patient had to pass through in the course of the therapy in order to find his melody. In each of these phases, he increasingly gains his identity, which finally enables him to express himself fully in the 'Farewell Melody'. The three phases thus form a precondition for the creation of the 'Farewell Melody' (see Figure 13.2).
- The way in which the patient gathered experience becomes clear in the categories of constructs. The categories orientation and search gave the patient access to his will-power, on the basis of which he was able to take decisions (decisiveness). The energy involved is also a source of his emotional need for expression, which, in an effort for clarity, has induced the category transformation. This transformation takes place on an outer, active level but also internally, insofar as the patient is able to permit such

a transformation. He thus finds his inner self, and then he is able to express his confidence, inner balance, personal integrity, autonomy and personal identity. These stages of experience as illustrated in the categories culminate in the 'Farewell Melody' of the last therapy session.

### *Choice of instruments*

Another interesting development may be seen in the way the patient himself selected the instruments. In the course of the four sessions, the patient shows more differentiation in choosing instruments and possible ranges of sound. On the conga drum (first session), he already experimented with the contrast between low and high pitch on a drumskin. He expanded this contrast with the tom-tom, which provided two different resonant bodies and two sounds of imprecise pitch. He then decided on the temple blocks and thus had five different sounds available. This already indicates a tendency to differentiate, which culminates in the choice of the vibraphone. This specific choice of instruments suggests that the melodic element has increased in significance for the patient over the therapy course with an ever-increasing differentiation and precision of tone.

### *Development stages and the principal-component analysis*

Figure 13.3 is based on a principal-component analysis of the construct data and illustrates the course of the melody generation in the context of the therapeutic relation.

Principal-components analysis is a technique for simplifying a data set, by transforming the data to a new coordinate system such that the greatest variance by any projection of the data comes to lie on the first coordinate (called the first principal component), the second greatest variance on the second coordinate, and so on; in this case, the construct 'rhythmically related/melodically related' playing and the construct 'clear/vague'.

The vertical dotted line (clear/vague metre) and the horizontal dotted line (rhythmic/melodic relation) represent the two essential axes indicating the changeability of data (episodes). These episodes are marked 'x' and their numbers and appear in their location with the pertinent abbreviations. A line then connects the patient's way towards his own melody, with an arrowhead showing the direction of change.

At the start of the therapy, the patient depends on the therapist in rhythmic relation and is only able to express himself via an unclear metre (way from Episode 1 to 3). Later on, he obviously tries to disengage himself from the therapist but maintains his unclear expression in playing (way from Episode 3 to 4 and 5). In his unclear metric playing, he is drawn back into dependence (way from Episode 5 to 6).



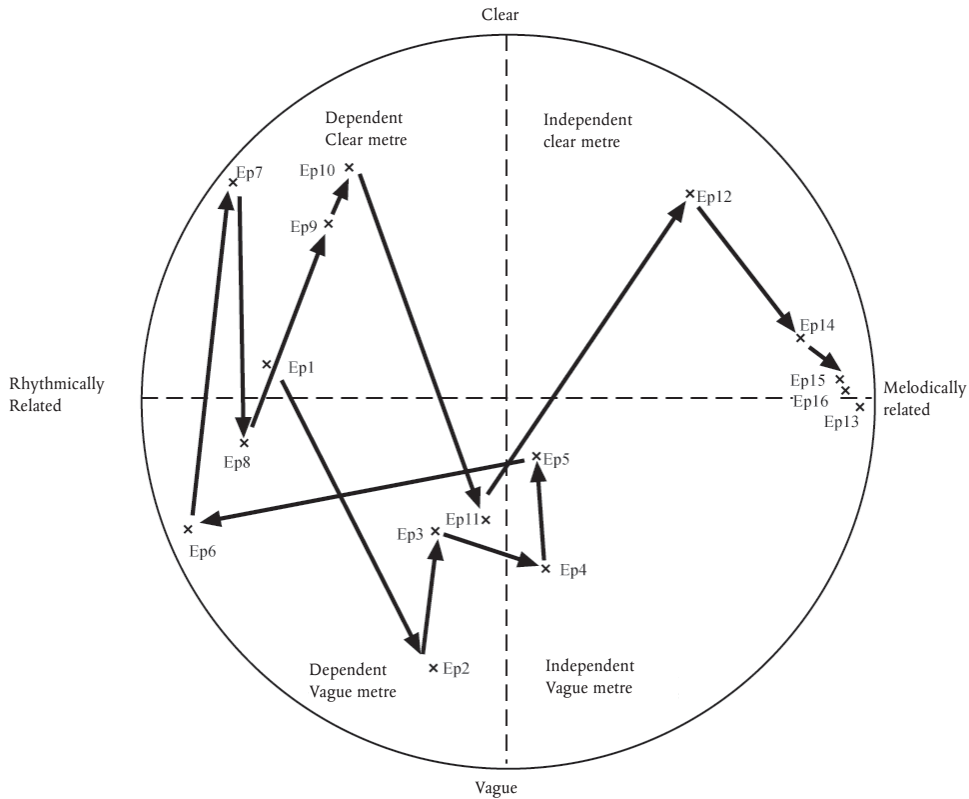


Figure 13.3 Map of therapeutic relations

Subsequently, and still dependent on the therapist, he is guided towards a clear metric play (way from Episode 6 to 7) which, however, he is unable to keep up; again he relapses into unclear playing (way from Episode 7 to 8). From there, and still dependent on the therapist, he finds clarity in his playing (way from Episode 8 to 9 and 10), then there is another relapse into unclear playing (way from Episode 10 to 11), and this time he gains his 'autonomy'. He emerges with a clear form of playing (way from Episode 11 to 12, 13, 14, 15 and 16).

Consequently, we may state that in the therapeutic relationship the patient vacillates between dependence and autonomy and is unable to change the unclear quality of his playing. In dependence on the therapist, he hesitates between unclear and clear expression until he has found his personal clear expression independent of the therapist, and this again leads him towards his melody on the basis of a clear metre. This suggests that the patient in his search for autonomy must acquire clarity; without clarity, autonomy would have no significance for him, or would not have been achieved in the first place.

## Evidence of development in some musical examples

### *Cycle of categories in the first phase of development*

This section quotes some musical examples as evidence of the melody development in this second study.

Within the first phase (see Figure 13.4) of 'development' we found that the patient passed through the categories orientation/search, or search/orientation, and arrived at decisiveness, which gave him access to transformation and eventually to self-discovery. The examples in Figure 13.4 illustrate this path.

The musical example in Episode 1, bars 7–8, shows a pattern of orientation characteristic of the patient. On the basis of the previous supporting quaver metre and the emerging half-phrases in the therapist's play, the patient anticipates the stresses, which he 'strikes up' in upbeat crescendo and accentuates. He thus demonstrates that he is able to focus on, or adjust to, something (in music: metre, beat, form) and somebody (therapist: change in form of playing). His attitude is also revealed in the interruption (rests on the second and third beat), which implies a simultaneous impulse for a dialogue.

In connection with his orientation, the search for expression becomes apparent. The example in Episode 4, bars 7–9, shows that from a 'standstill' the patient changes over to something open and indetermined; tentative, calm, reticent, he gropes around for a mode of expression. The upward-flowing sequence of notes played by the therapist first gives him more cohesion which, in combination with a starting tremolo, again indicates the characteristic play towards an accent (stress).

These forms of experiencing one's inner self within both categories guide the patient towards decisiveness, which becomes apparent in the example of Episode 4, bars 22–23. The anticipated melodic contour at the end of the upward melody line helps him – via the 'turning note'  $g^2$  (crotchet rest) – to come to a decision and, following the downward melody line, to opt for a clear tempo in a well-defined beat. This step implies his decision for a clear form of relationship with himself and also with the therapist.

The active component which the patient sensed in contact with his decisiveness leads him towards transformation, where he is able to vary, to change and to modify the musical material. In Episode 5, bars 3–4, the patient reacts spontaneously to the therapist's relaxed voice part and starts complementing it in close musical contact. In doing so, he disengages himself from his previous rhythmic accompanying motif and varies his voice in accordance with the joint interactive music-making.

This experience, of being able to change something and to feel this change in oneself, leads the patient towards the category of self-discovery. As stated earlier, self-discovery in this context means an approach towards a more conscious 'self'. In

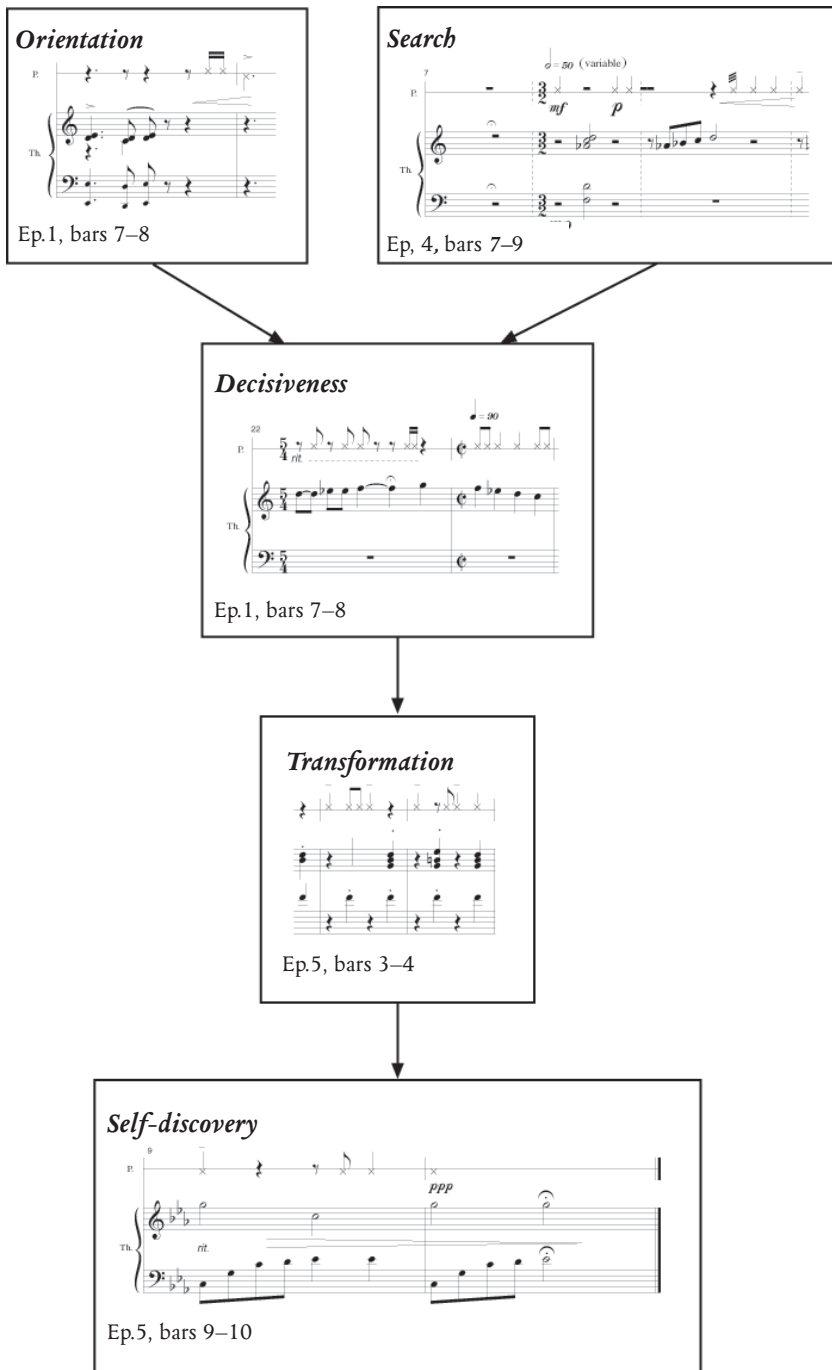


Figure 13.4 Examples of categories and their development in the first phase of the therapy process

Episode 5, bars 9–10, this becomes audible in the patient's deliberate reference to and focus on a melody note which he prolongs, stresses in timbre (lower timbre) and thus expands. With this more differentiated mode of expression, where the external activity becomes an internal one (deepening of the melodic tonal experience), the patient gives himself more room to sense his own identity, to experience and to recover it.

### *Categories of constructs in the course of the melody*

The following examples combine in their melodic forms those characteristics that emerged earlier in the examples of categories of constructs as we saw in Chapter 12. The patient vacillated between dependence and autonomy in his therapeutic relationship; consequently, two modes of presentation are employed in this second study. The first includes the therapist's voice, in accordance with the significant interpersonal relation. The second presentation focuses on the patient's voice exclusively to better illustrate how he found his own melodic expression.

#### MODE OF PRESENTATION 1: PROCESS OF CATEGORIES OF CONSTRUCTS IN THE CONTEXT OF INTERPERSONAL RELATIONSHIP

The patient establishes a relation with himself. He finds orientation within the melodic frame of a fifth and looks for a possible mode of expression in the repetition of motifs (see Figure 13.5).



Figure 13.5 Example 1, bars 2–5: orientation, search – intra-musical

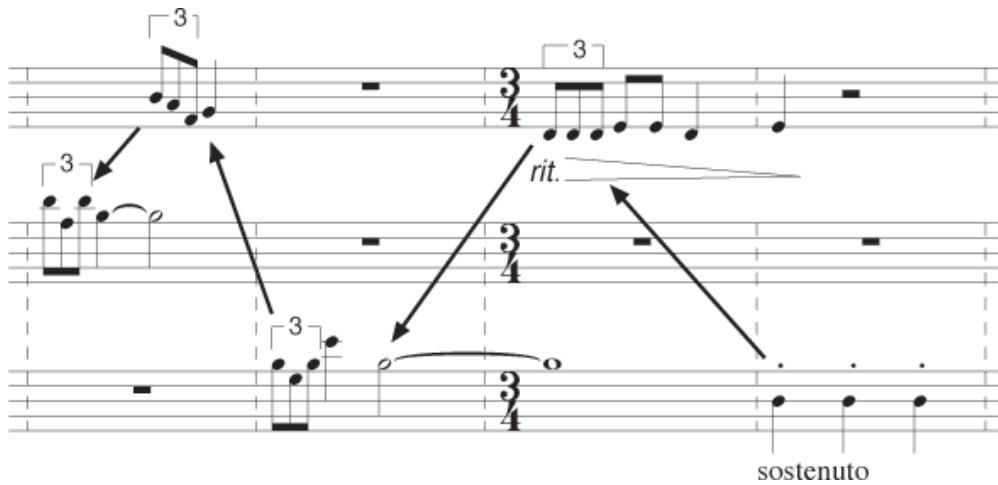


Figure 13.6 Example 1, bars 6–9: orientation, search – inter-musical

In bars 6–9, the patient finds orientation in the voice of the therapist who meets him with similar nodal figures (see Figure 13.6). The patient thus links up with the therapist in sound ( $h^2$ ) and timbre-motif (tritonus  $h-f$ ) and leaves room for a short interchange. Orientation and search clearly indicate an intersubjective component in this context.

The patient takes up the therapist's melodic figure ringing out above the dominant seventh chord (bar 14) with the same initial note ( $h^3$ ) and expands it in striving for a new expression in *ritardando* and *crescendo* (see Figure 13.7). Thus he underlines the transition and, at the same time, announces both an imminent change and decision. This decisive change is directed towards the formation of a melody, on the foundation of a tonal basis (C-major), an underlying pulse and a definable time structure in a slow, sustained tempo. These bars illustrate that the intra- and inter-personal relationship was a precondition for the patient to achieve clarity in his play in that he waits for the keynote struck by the therapist (Figure 13.7).

Decisiveness and transformation emerge here on the basis of the close intra-personal relation and become musically apparent in the joint dividing of the melodic contour, both players waiting for each other (see Figure 13.8). The patient changes his previous motifs that we have heard in the episodes into melodic 'sigh motifs', which he delays slightly in expectation of the harmonies that the therapist introduces, so that the resolution of the suspensions become effective.

With the crotchet rest, the patient shows that he is waiting for the basic (key) harmony. At the same time he modifies and expands the melodic key motif of bar 16



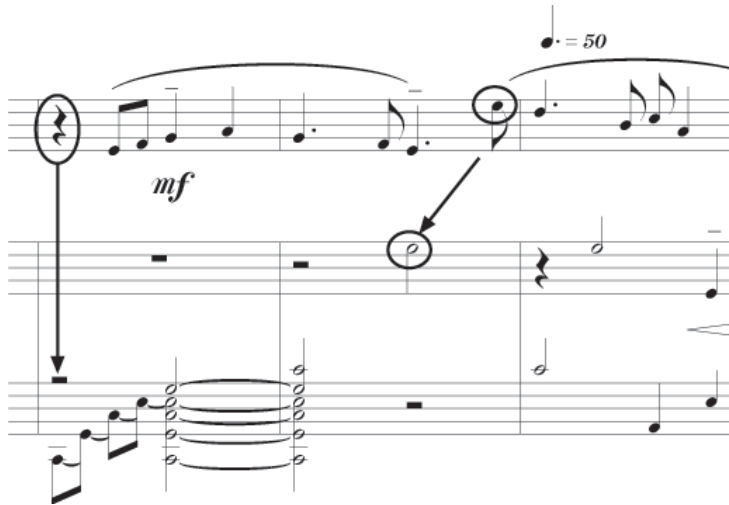


Figure 13.9 Example 2, bars 22–24: transformation – harmonic relationship

The new decision for a different melodic expressiveness which becomes unmistakably clear in bar 28 is also taken on the basis of the inter-personal relationship (see Figure 13.10). With the introduction of the quaver triplet, played by the therapist in bass accompaniment, the patient changes the rhythmic–metric character that finally leads to the new 6/8 time. On the basis of the harmonic relation, the melodic



Figure 13.10 Example 2, bars 26–30: decisiveness – change of rhythmic character and development of melodic contour

contour develops, which is sustained internally by both patient and therapist who take up and pursue individual notes ( $a^2$ ,  $b^2$ ,  $d^2$ ).

Self-discovery develops in the patient's play with the new and subtle melodic expression (from bar 28 onwards) and gains confidence in the clear expression of the independent melodic lead and conclusion (see Figure 13.11). The latter is underlined in the patient's own way: the three-tone motif standing out clearly, descending ritardando to the accented key note  $c^1$ , which as tonic chord is prolonged rhythmically and implies the harmonic interpretation of the submediant by the opening of the tonal range towards  $h^1$  with suspension to the sixth.



Figure 13.11 Example 2, bars 34–36: self-discovery – three-tone motif

The patient's self-discovery is evident here in the leading and dynamic quality of his melodic play (see Figure 13.12). His heightened sensitivity translates into intensified expression, which rises to the tonic. Immediately prior to self-discovery in the intensified expression, a connecting element emerges in the patient's, and therapist's, play (bar 39) revealed as a simultaneous and inverted suspension.

Similar to the conclusion of bars 34–36, the clear self-reference of the patient is obvious here, which he makes conceivable for himself with the help of a concluding figure (see Figure 13.13). What transpires here is the patient's growing self-reliance and autonomy.

In bars 57–59, the patient gains a new and deeper identity (see Figure 13.14). This becomes apparent in his melodically well-formed, almost composed, escalation of tension up to the clearly stressed culminating point, which is particularly





Figure 13.12 Example 2, bars 39–43: self-discovery – simultaneous and inverted suspension



Figure 13.13 Example 2, bars 48–50: self-discovery – the concluding figure

expressive due to the suspension to the tonic (fourth suspension). Rhythm, diastemy and dynamics are closely integrated and interwoven. Something becomes apparent here which the patient experiences as a feeling of evidence. This is a sensation that his inner experience is in tune with his perception of the external therapeutic situation, which is based on trust and despite the patient's lead impresses him as



Figure 13.14 Example 2, bars 57–59: self-discovery – a deeper identity

being in contact with the therapist. The patient's growing self-assurance and confidence serve as a basis for the process of his self-discovery and identity development, which find expression in autonomous action.

A new process of self-discovery or development of identity is evident in the gradual dissolution of the melodic intensification, which is reduced step-by-step and guided back towards relaxation, a rest (see Figure 13.15). The patient's identity reveals itself in a pure, soft, differentiated and subtle expression.

The regained identity also emerges in the last bars of the melodic improvisation (see Figure 13.16). The patient finds his self in the fading and concluding bars, which unmistakably indicate the end of the previous jointly experienced and exciting intensification of the melodic expression. He is able to say good-bye.

#### MODE OF PRESENTATION 2: MELODIC EXPRESSION

The subsequent second mode of presentation focuses only on the patient's melodic voice in order to illustrate more clearly the development in the process of finding his melodic expression (see Figure 13.17).

Through the categories of decisiveness and transformation, the patient evolves the initial descending thematic form – which serves as an intra-musical orientation – into a comprehensive melodic form (example 2, bars 16–36). This unfolds gradually out of the melodic motif introduced in bar 16. In an altered version it also forms the

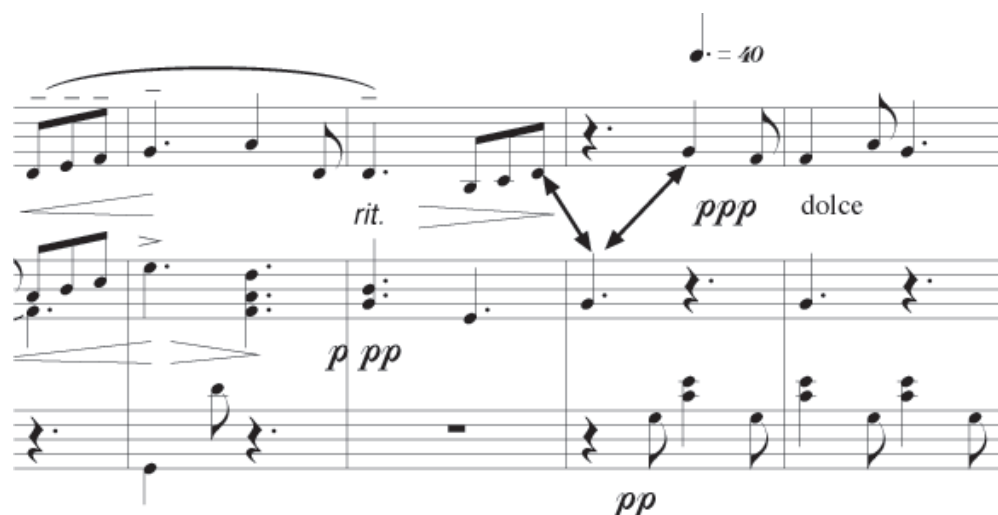


Figure 13.15 Example 2, bars 64–68: self-discovery – dissolution of melodic intensification



Figure 13.16 Example 2, bars 82–85: self-discovery – the concluding bars

basis for the category of self-discovery with which he finally reaches the melodic climax (example 2, bars 50–67) and the conclusion (example 2, bars 74–85) of the 'Farewell Melody'.

The last session again repeats the cycle of categories, this time with a focus on self-discovery.

The musical–melodic characteristics of the 'Farewell Melody' suggest that both players have their own individual and independent expressive forms that come together as a unified piece. The patient assumes the musical lead and achieves

Example 1, bars 2-5 *Orientation (intramusical)*Example 2, bars 16-23 *Decisiveness, Transformation*Example 2, bars 23-27 *Transformation*Example 2, bars 28-36 *Decisiveness*Example 2, bars 50-67 *Self-discovery*Example 2, bars 74-85 *Self-discovery*

Figure 13.17 Changes in the patient's melodic voice following the construct categories

independence from the therapist. In this context, we perceive him again with regard to his intra-psychic regulatory processes that became apparent in the patterns of interaction. The patient's inner process of synchronization has enabled him to modify his initially isolated and inflexible modes of expression and to integrate them into a wider melodic context. This reflects his inner experience. He is also in tune with the therapeutic situation, that has become based on mutual trust. Through his independent, autonomous melodic lead he remains in contact with the therapist.

## Significance and Relevance

One objective of this study was to see how melody develops in a series of music therapy sessions and this has been achieved. We also hypothesized that melodic improvisation offers patients a chance to bring their intense and, to some extent, contradictory emotions as inner realities, into an externalized, expression both dynamic and changeable. We see in both these studies the ontogenesis of the melodic shape and the meaning of the developmental process as this occurs for both patients. In addition, we also see how both patient and therapist reached those moments from which the melody of the previous session develops. In other words, both studies looked into the musical elements and transitional forms that determined the creation of the melodies occurring in the last sessions of these two studies. We see commonalities in both studies.

### ‘Original form’

In both studies we discern something like an ‘original form’, out of which the melody of the last session developed. In the first study, this is an iambic foot that first appeared in Episode 3. In the second study, the prosodic form of an anapaest,<sup>1</sup> which in the course of the therapy changed from imprecise musical utterings to a clear melodic manifestation. These melodic forms chosen by both patients individually served as elements of communication with their inner selves and also with the therapist. Both elements acted as patterns of interaction, to be integrated into the therapist’s clinical improvisation. Consequently, they contributed to the development and emergence of the melodic form.

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1 An *anapaest*, like the iambus, is a metrical foot used in formal poetry. In classical quantitative meters it consists of two short syllables followed by a long one (as in a-na-paest).

A rhythmic form with a stabilizing effect is an important precondition for the emergence of a melodic form. Previous rhythmic experience plays a vital part in melody development. As a consequence of this previous experience, rhythm here became the substance of melody in both cases, in that rhythm and melody blended into each other.

## **Harmonic form**

In both studies, previous rhythmic experience was not the only element of significance for the melodic development of the original form. For both aspects to develop in their respective individual expression, an appropriate setting – a fitting, harmonic milieu – had to be created. In addition to the rhythmic form, the harmonic form had to be integrated, which for patients in both studies served as a basis or background for the development of their melodic phrases. Both patients obviously require harmony as a fundamental means to individually create melody.

We have seen at the beginning of this book that, from a historic and aesthetic perspective, the functional relevance of harmony was a supportive background against which diastematic–rhythmic events could freely stand out. Harmonic relevance is also discussed in current music theory (Bozzetti 1988; Cook 1995; Cooke 1982; Moraitis 1994; Schoenberg 1967; Varese 1987). The therapeutic significance of harmony shows not only in the unification and support of the patient's melodic voice but also in the promotion and shaping of its individual development and expression. A psychologic–therapeutic significance is clearly revealed in the instigating, stimulating and balancing effects.

Bearing the socio-cultural context in mind, we argue that harmony does not constitute the opposite of melody. It appears here in its well-known and generally understandable structures of the major–minor tonal system, which are part of the transcending characteristics of our Western culture to which both patients relate.

## **Harmonic form as a generally transcending cultural fact**

In the light of this socio-cultural context, we may quote the thoughts voiced by Rousseau. Rousseau was known not only as a political thinker but also as a musician and music theorist (Scott 1997). In his works on music and language he developed a theory on the natural foundation of culture in all its manifestations. His theory focused on the human capability of discerning and communicating emotions in their many different forms of expression. It explains the variability of human emotions and their many forms in different sections of the population. A common feature is the affective cultural basis of shared emotions, passions, customs and moral rules. As a consequence of shared cultural meanings, the different emotional forms of

suffering, joy or agitation expressed in a melody are therefore understandable for each individual.

Against this background, we may discuss the relation between the melodies in both studies and the harmonic context created by the therapist. Both patients communicated their feelings via the subjective expression of their melodies. According to Rousseau, the various emotions expressed in language and melody are understandable to people of the same cultural tradition. The individual with his affective, idiomatic way of expressing himself has to cope with the cultural environment in order to maintain his connection with society. Harmony may be seen as an integrative element to which the individual may refer in his spontaneous, subjective and autonomous expression. He may thus find his appropriate cultural setting. Whenever the laws of the cultural setting have been broken up, however, the individual is no longer able to refer to it since he does not understand the language any longer. This is why therapy will be successful only if the cultural context of a patient is taken into account and if he can re-establish contact with his cultural environment by way of familiar forms of expression.

To be expressively articulate, we need both an expressive repertoire and a milieu in which that repertoire can be performed with others. This repertoire and its milieu is the dynamic activity in which we take part known as 'culture'. As we argued earlier, culture is performed, and may be better expressed in the verb form as 'culturing'. In this definition, it remains active and dynamic rather than the static 'culture'. For both the patients in these studies, they needed to find appropriate expressive forms that rendered their interior milieu external, and in this rendering, also allow them a form of reflexivity. What we find in therapy is a form of reflexivity achieved through another person. We are able to hear how we sound in play with the other. I know who I am through you and your reactions. What therapy brings to this situation is a potential for expression that is both new and adaptable, which remains however within parameters that are in continual negotiation – that is relationship.

## **Independence**

Given that relationship is an important factor for achieving expression, then we are faced with how to achieve independence. Independence in the form of assuming personal responsibility for one's actions is one of the basic objectives in each therapeutic approach. Both studies demonstrate that independence is the main issue. It constitutes the end of the treatment phase and is closely related to the ability both patients have acquired to create melodies independently.

The process of establishing relations in any kind of therapy is generally considered an important and critical aspect of therapy. In the improvised music therapy

approach selected here, the relationship aspect is attractive insofar as it may develop in the course of the performance in non-verbal form (where language-related problems of communication cannot occur), the performance allowing a mutual adjustment or tuning in unlimited, varied facets, and a simultaneous mutual (patient/therapist) experience in specific temporal dimensions. In both studies, it was possible to follow closely, and characterize, the process of establishing a relation over the demonstrated therapy phases. This process revealed stages of insecurity, uncertainty, search, orientation and decision-making, and with the melody of the last session it culminated in the experience of one's own identity and personal expression. In those moments of interaction, this experience was successfully coordinated with the experience of the therapeutic relationship.

This mode of gaining an identity may also be analysed against the background of a concept of identity, which in our post-modern society turns out to be manifold and something which defies objectification (McNamee 1996). Its significance becomes apparent only in the context of the therapeutic relation. Jung sees the individuation process as essentially influenced by relational phenomena; indeed, he defines it as an internal and also external relationship process, whereby the processes of understanding and of relationship form an inseparable unit:

The individuation process has two principal aspects: on the one hand, it is an internal and subjective process of integration, and on the other an indispensable and objective process of relationship. One cannot be without the other, although either one or the other may be in the foreground sometimes. (Jung in Schulz-Klein 1997, p.50).

This applies not only to individuation in general, but also to therapy.

In both studies, the individuation process developed during the phases of intra- and inter-personal relationships. We have seen in both studies that in the therapy process the musical negotiation of intra- and inter-personal relations played an important role, out of which both patients were able to achieve a phase of independence that resulted in self-discovery. This is an essential experience if we think of the challenges inherent in our quickly changing pluralistic society. The anchoring of the self in the musical expression of their personal melodies helped both patients to strengthen their inner stability. They thus experienced a self to which they were perhaps closer than in expressing with words.

In this context the role of the therapeutic relationship must be underlined; it provided external definition and guidance to both patients in finding their inner self. The musical interventions addressing the patients from outside were a challenge to come to terms with unfamiliar and different modes of expression. A music therapy approach which has the advantage of encouraging individuality and thus of facili-



tating the expression of a unique clinical expertise must face the danger of solipsism, raising one's own personal values to the level of generally applicable values. It is this danger which Aldridge underlines:

The danger is that groups ... are so convinced of their own unique value that they believe that all others should work in their superior way and that they have the right to dictate the standards of individuals. This is tribalism and is the ultimate danger in a post-modern society. (Aldridge 1996a, p.279)

## **Expressivity**

In this therapeutic improvisation, expressivity took the form of a definite activity, not an abstract concept but rather something that was successfully given a material manifestation.

In both cases, one of the patients' difficulties was how to cope with their inner feelings and strong emotions, at a time of particular vulnerability and distress. We know that when emotions like anxiety and insecurity are not handled adequately and become detached from the individual and the social context, they become pathological. However, in these studies, melodic improvisations helped both patients to achieve an ecology of form for their inmost feelings and emotions comprising the self and the milieu that included the therapist. This is another occasion to highlight the potential inherent in a creative, non-verbal therapy approach, where feelings are not defined as rigid terms. In musical improvisation, they reveal their dynamic character and development. They appear in ever-new manifestations, and in the experiential process they may be repeated and explored in depth, but also left behind, changed and expressed in new ways. Both patients used their melodies in order to achieve a musical ecology of feelings that brought them into close contact with their therapist.

## **Significance of melodic development in a therapeutic setting**

Melody is one of the most powerful vehicles of expression in our Western culture. Melodic forms serve particularly well to communicate human emotions and for this reason alone are of therapeutic significance. The explicit study of music is not considered a necessary precondition for perceiving subtle structures in tonal, musical sequences. Bigand (1997) found that, in general, musicians and non-musicians respond to the same musical characteristics in the same sensitive way, whereas musicians tend to concentrate their knowledge on tonal hierarchy.

Playing and developing one's own musical forms directs the attention to the structure of phrasing, which plays an important part in the cognitive processing of

musical sequences (Chiappe and Schmuckler 1997). It serves as a functional unit guiding musical processing of musical structures in perception. Melodic phrasing and the direction of melodic contours not only influenced the patients' anticipation and memory but also encouraged them to structure their musical sequels.

### *Concept of an expanded self*

Awareness facilitates a greater sense of responsibility as well as freedom and choice. (Muran in Blatt and Segal 1997, p. 83)

Psychotherapeutic literature often discusses concepts of an expanded self – independent of the modalities to achieve this (Blatt and Segal 1997; Segal and Blatt 1993; Wolfe 1995). For persons suffering from depression, this expanded perspective is seen as relevant as it allows patients to develop a greater functional sense of self.

Blatt and Segal (1997) find a prevalent attitude in literature that underlines the need to consider the self within its pertinent context. The client/therapist relationship thus constitutes the primary vehicle for an effective observation of the various aspects of self. According to Muran (Blatt and Segal 1997, p.82), the therapeutic relationship is a laboratory comprising many different I–You combinations that have to be understood in this relationship. The therapeutic relationship thus becomes a kind of screen on which the I–You combinations represent the self are depicted. Re-present can be used here as to present the self again to be performed again, anew, in a relationship thus potentially reconfiguring the relationship. In this book, we see how musical figures are constantly being reconfigured, retaining their identity to maintain continuity but allowing enough flexibility to achieve new configurations.

Authors also stress the relevance of incorporating the therapist's intuition and own emotions, since these are the main source of discovering affective notes in relations, which then find expression in therapy. How therapists handle the combinations of the I–You relationship influences the therapy effect of their treatment approach. Against this background, and the findings of the study, the individual development potential of a melody offers patients a chance to achieve an expanded self and – in the course of the therapeutic relationship – to gain clarity of expression that facilitates understanding and awareness of the expanded aspects of self. This expanded self is one of performance; we are the milieu for that performance of self in which configurations are possible.

## **How to develop a melody within a therapy phase**

The findings of both studies offer some practical steps for therapy that will support the emergence of a melody.

### SINGULAR ELEMENTS; INCLUSIVITY AND ACCEPTANCE

The focus must be on a patient's musical voice and on everything he/she introduces into the play, even unclear, singular elements with indistinct, obscure musical statements however hard to define. It is possible that they conceal a patient's musical characteristics and peculiarities. These elements may serve as points of reference for subsequent patterns that lead to coherent phrases.

### EXPERIMENTATION AS SPONTANEOUS PLAY

In phases of experimenting, singular elements may be used playfully. The factor of indetermination forms the basis of spontaneous, immediate activity, either with or without intention.

### PHASES OF EXPANSION AND INTENTION, ROOM FOR EXPANSION

Both patients revealed tendencies that clearly indicated a certain direction in which they wanted to develop and signal their intentions. These must be given room so that they may be expressed without restriction.

### REPETITION AND IMITATION FOR ORIENTATION

Repetition and imitation are important for a patient's orientation within his or her own individually created spheres of sound. They are also essential in confirming their own self, which they experience in slightly altered repetitions. In all episodes, varied repetition and imitation are employed as consistently applied clinical techniques.

### OFFERING THE APPROPRIATE CONTEXT

An appropriate context is to encourage a patient's actual expressive potential and to prepare the ground for possible change, development and growth. To establish such an appropriate emotional background may promote assurance and confidence, which again serve as a basis for a new sphere for creative development. To develop and establish an appropriate context was a definite objective in all episodes.

### IMITATION, ASSIMILATION, INNOVATION

Change occurs within cycles of development. It is important to recognize these cycles and allow them to develop. One cycle here comprises imitation, adaptation, integration and new creation.

### EXPANSION OF THE CONTEXT

In developing and shaping one's personal melody, a patient may create his context himself. The melody rings out and develops not only above the supporting sound background provided by the therapist but now forms its own, independent sphere of sound.

The creation of the melodies 'A Walk through Paris' and 'Farewell Melody' was only possible for both patients with the support and expansion of the general musical context. They were guided through various spheres of musical experience in rhythmic, metric, dynamic, agogic, temporal and tonal expression. They had to pass through the various areas of musical expression in order to make contact with the inner aspects of their self. Eventually, they reached their own inner voices, which they discovered in the specific timbre of the metallophone and the vibraphone. Both patients succeeded in expressing their inner qualities in a comprehensive melodic form and thus found a positive way to bring the theme of their identity into the open in an active and creative manner. Both themes become evident in their coherent qualities of form that combine all musical attributes. They suggest a holistic experience that may evoke feelings of completeness and absoluteness that is fulfilling.

### STYLE

The way in which the patients present themselves and their innermost theme in life may be called style. Music therapy might help individuals to find their own style. In jazz, this is a core objective:

You move from the imitation stage to the assimilation stage when you take little bits of things from different people and weld them into an identifiable style – creating your own style. (Walter Bishop in Berliner 1994, p.120)

The benefit of style is that it escapes the psychological restraints of personality. It is not something that brings us into the constraints of being normal but allows us to be different. It places who and what we are truly in the sphere of the performed arts and the aesthetic.

### ‘AESTHETIC AS PERFORMANCE’

This has been a hermeneutical study, the methodological study of musical texts. As we saw in Chapter 1, art is an activity. The work and its viewer, the patient and her sounds are as important as the therapist. Art is the happening and becoming of understanding, not fixed but performed. This is the destruction of objectification and the prioritization of experience; it works against the demands of evidence-based medicine. Doing art, making music, performing dance has a moral and practical value for people as it encourages us to break free of convention. Works, as workings, became intimate performances as relationship with the audience. Here we have the praxis aesthetic and a relational aesthetic proposed (Aldridge 2000). These aesthetics are based upon relationship, and intimate performance, with mutual moral responsibility for each other. They are also potentially revolutionary as conventions are challenged.

In such a relational context, therapy becomes a meaning-making activity where the truth is not determined, conventions are broken and sense is performed. There is a mutual performance of meaning. Aesthetic is dislocated from the purely privatized to the relational and contextual. We have another perspective on truth claims. These are the modest truths of living in the validity of the other – mutual recognition. There is no radical separation between musical work and performers. The challenge for music therapy research is that, if the aesthetic is relational, it is not a quantifiable thing. We must, as we have seen here, adopt a hermeneutic perspective.

### Coda

The meaning of music is a much-discussed phenomenon. In this book we see how a neutral music analysis can be made from the structural elements of the music itself and how meanings are imposed on musical events. We make clear that those events are chosen, as episodes, from a broader field of musical events and then offer a structured method for construing those events and their understandings.

The understandings elicited in this book are from one of the participants in the music-making, the music therapist, as the focus of the work is her understanding of how melody develops when she works with patients. It would be another study altogether to include the understandings of the patient and we suggest caution on two counts:

- It is potentially challenging for patients to verbally reflect on music therapy and be in a therapeutic situation at the same time – playing and talking about the meaning of that play are two different activities

- While the music therapist has a developed musical vocabulary and experience of analytic listening, patients are relatively restricted, and certainly unpractised, in their ability to analyse on a technical basis what they have played. We have suggested elsewhere that when working with people suffering with psychosomatic problems, it is the non-verbal therapies that are effective in that they match the presentation of the symbols – both forms of expression are non-verbal. Indeed, symptom expression may be a cultural form of expressing personal distress (see Aldridge 1998 on suicidal behaviour)

We have the original audio recordings of the sessions and these serve as a backward chain of evidence in that we can demonstrate, if necessary, the musical events from which we have provided the scores of the episodes.

While meanings are often applied to music from outside, we also see how the way that music events are structured here offers possibilities for understanding social and relational events. However, the focus here is on ‘musicking’ (Small 1998); that is, the process of music-making, and this has its ramifications for relating and socializing. In terms of emotions, we can postulate an emotional process where feelings are negotiated in relationship. We have the core motif, and an analogous emotional core motif, that is developed in interaction into a musical and affectual relationship. The emotion itself can remain nameless; nevertheless, it can be experienced, achieve both form and expression, and reach closure.

While there is a continuing debate about music and the emotions, there is a parallel understanding that is concerned with emoting and the completion of emotional satisfaction in relationship. Our argument is that such a dynamic, processual argument is more relevant to the nature of understanding emotions and music than an ascriptive, static denotation through verbal labels (*de*-notation in the sense that the musical notes are removed, just as much as the conventional sense of denotation as literal or logical meaning). Indeed, we propose the view that understanding the process of musical improvisation in therapy may offer ways of understanding other processes of therapy and other processes in daily life. Rather than looking for external applications to understand music, we propose that understanding the mutuality of music-making allows us to understand other social processes of negotiation and relationship. This builds on the premise in our earlier works that biological form can be understood through principles of musical form; both are improvised dynamic compositions that occupy a transitory temporal space. Instead of looking at other processes to understand music, we propose that understanding musical process allow us to understand relationship and the dynamics of social forms as per-form-ances (Aldridge 2005).

Small (1998) emphasizes the influence of Gregory Bateson on his thinking, and the same holds true for the reasoning in this book. Rather than locate emotions in one person, we understand emotions as a description of a pattern of interaction within an ecology of meanings (Bateson 1972, 1978, 1991; Aldridge 1985, 1998, 2000) within a relationship. Meanings are used here as understandings that also may not have reached verbalization nor verbal expression. This presupposes that we have a way of knowing the world that is non-verbal and not always present in everyday consciousness (Small 1998).

As to scoring the musical material, that itself is a prior interpretation given that the music was played without bar markings, and putting the music into a conventional time structure is a preliminary act of interpretation. We had to choose a particular convention, as the alternative would have been to construct a new system for improvisation notation in therapy, a project in itself.

Tia DeNora (2000) has urged us to look at music in everyday life, and she uses music therapy as one of the examples. From her perspective, music not only allows us to feel empowered but is empowering through the gaining of a capacity. We see here in the two studies how such capacities can be gained, and these capacities are simply those of performing everyday life: per-form-ing as bringing life into form – that lived wholeness of everyday life in all its buzzing, singing, physical, psychological, relational existence. Earlier, we used living as jazz as a rather fanciful metaphor for describing the connection between music and the process of living; this is not simply meant as a physical analogue but as a basic existential principle. Our lives are improvised forms with others, not fixed, yet with coherent themes, that we recognise from one situation to another and which, in this situation, we call melodies. Performing melody is an expression of the creative process of an emerging sense of being, the ephemeral trace of a deeper process.

## **So what is melody?**

*Melody is the outward expression of that pattern which connects.* The task of scientists and artists is to discover those patterns that are implicit in the world which connect us. In the therapeutic narratives here, we see how those patterns are made explicit. The melodies, performed as melodic improvisations, make explicit traces of that which is implicit. By performing, we give expression to the intangible. The real becomes apparent in that fleeting materiality of performance. This is a holistic activity. We have an embodied hermeneutic that needs to be performed for us to exist in the world. And this existence is with others. To understand what it is to be human, then make music.



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Melody is regarded as the 'essential core' of music. In the context of music therapy, looking at how patients develop their own melodies in improvisation can explain how they find their own voice and determine their position in relation to the world, and can also play an important role in how they relate to their therapist.

Gudrun Aldridge and David Aldridge explore the concept of melody within its historical context and investigate current theories of melody. They develop a new method for analysing melodic improvisation, called 'Therapeutic Narrative Analysis', and utilize this case study approach to demonstrate how such an analysis can work in practice. They show how the interaction between patient and therapist is affected by the patient's melodic statements, and how the process of improvisation offers patients a chance to transform their inner experiences into externalized expressions.

*Melody in Music Therapy* is an important addition to music therapy literature, and will be of interest to music therapists, educators and students, as well as musicologists.

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Jessica Kingsley Publishers  
116 Pentonville Road  
London N1 9JB, UK  
400 Market Street, Suite 400  
Philadelphia, PA 19106, USA  
[www.jkp.com](http://www.jkp.com)

cover design by C.P. Ranger

